

HANDBOOK OF HEALTH PSYCHOLOGY

SECOND EDITION

EDITED BY
ANDREW BAUM
TRACEY A. REVENSON
JEROME SINGER

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To the memory of Andy Baum (1948–2010) and Jerome E. Singer (1935–2010), who have left their intellectual handprint on the field of health psychology; and to my husband, Ed Seidman, for his unconditional love, to my daughter Molly, my beloved principessa, and to the memory of my father, who believed I could become anything I wanted.

Tracey A. Revenson

New York City

January 2011

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Preface

Since the publication of the first edition of the *Handbook of Health Psychology* (Psychology Press, 2001), enormous progress has been made in the connections among biological, psychological, and social components of health, health behavior, and illness. More important, scholars in the field have expanded this tripartite model across even more levels of analysis, including cultural and macrosocial factors at one end and cellular factors at the other. Moreover, a new emphasis has been to translate research evidence in to practice and policy.

The second edition of the handbook reflects these changes and is quite different from the first in terms of both approach and content. The 34 chapters are written by some of the top scholars in health psychology. Each author has taken seriously the task of providing a theoretical foundation, synthesizing and evaluating the empirical evidence, and contemplating how the state of the science can inform future research, clinical practice, and/or policy. The book maintains the first edition's framework of the biopsychosocial model, but the choice of topics reflects the advances that have been made in the field over the past quarter century. Specifically, this new edition adds sections on risk and protective factors for disease and on macro-level factors that affect health. We believe that this structure more closely reflects current scholarship in health psychology.

The first section, "Overarching Frameworks and Paradigms," presents the central theories that inform many areas of research within the field. For example, the concept of allostatic load is a "newer" stress theory that emphasizes the interaction of biological and social systems and may explain the onset of many conditions. The second section, "Cross-Cutting Issues," focuses on the specific mechanisms that help us explain the link between health and behavior across diseases and populations. The third section, "Risk and Protective Factors," new to the revised edition, focuses on specific variables that lead directly or indirectly to the onset and progression of major diseases or are instrumental in promoting health. Most of these risk and protective factors are applicable across many diseases. Some of the risk and protective factors are behavioral (e.g., smoking, exercise), some psychological (e.g., personality, depression), and some a combination of the two (e.g., obesity). The fourth section, "Macro-Level and Structural Influences on Health," also a new addition to the second edition, expands on the previous section. Although many structural factors can be conceptualized as risk or protective factors, this section highlights the larger (extraindividual) social and structural influences on health because this is a direction in which health psychology is moving. The final section, "Application to the Study of Disease," centers on translational research, taking the theories of the earlier sections and applying them to specific disorders.

The primary aim of this handbook is to provide current approaches to many of the critical topics in health psychology at the start of the 21st century. Because the handbook ranges from basic theories to cutting-edge research, to translation of the research to clinical practice and social policy and then cuts across concepts (e.g., behavior change), populations (e.g., women's health), risk and protective factors (e.g., obesity), and diseases, it is appropriate for a wide range of readers from a number of fields—primarily psychology, but also public health, medical sociology, medicine, nursing, and other allied health professions. The chapters are written so that they are accessible to a novice in the area, but they are also deep and detailed enough for a seasoned researcher. We see the handbook being used as a reference volume for those individuals who want to get a broad picture of health psychology as well as those individuals who want only a snapshot in a particular area in which they are working. It can thus also be used in graduate and advanced undergraduate classes, with chapters providing the "frame" for a specific topic.

Acknowledgments

There are many people who have contributed to the development of this volume over the years who deserve our heartfelt thanks. First and foremost is our editor at Taylor & Francis/Psychology Press, Debra Riegert, who remained a stalwart midwife of the second edition during the ups and downs of its birth. We cannot thank her enough for her support, persistence, and friendship. A second person who should be singled out is Phapichaya Chaoprang Herrera, MA, for her stellar work as the editorial assistant for the volume. Pang was always organized and gracious, the ringmaster of a rodeo of nearly 100 contributors and two vocal editors. The book would not have been completed without her, and we can't thank her enough.

We thank the contributors to this volume for their hard work, dedication, and vision, and to their stick-to-it-tive-ness. (You know who you are!) They are the marrow of the field of health psychology, and there would not be a volume without them. We also offer our gracious thanks to Cheryl A. Armstead, Regan A. R. Gurung, and Beverly E. Thorn, who reviewed the proposal for the second edition and made very smart comments.

Most of all, I thank Andy Baum and Jerry Singer for allowing me to be part of this endeavor from the first idea of a handbook in 1993. Though seldom in agreement, we managed to produce a volume that was true to all our visions. Andy, especially, I will miss our “lively” phone conversations the next time around.

Tracey A. Revenson

Editors

Andrew Baum was Jenkins Garrett Professor of Psychology at the University of Texas at Arlington (UTA) and director of the Center for the Study of Health and Illness at the time of his death on November 22, 2010. He earned his BS at the University of Pittsburgh and his PhD at the State University of New York at Stony Brook. Prior to his appointment at UTA, Baum served as professor of psychiatry at the University of Pittsburgh and professor of psychology, psychiatry, and neuroscience at the Uniformed Services University of the Health Sciences. Dr. Baum received multiple awards from such professional organizations as the American Psychological Association (Early Career Award and Senior Investigator Award) and the Society of Behavioral Medicine (Outstanding Service Award) for his contributions to the field of health psychology. Dr. Baum served as editor of two scientific journals, the *Journal of Applied Social Psychology* and the *Journal of Applied Biobehavioral Research*, and was associate editor of *Psychological Bulletin*. He served as president of the Division of Health Psychology from 1988 to 1989. He authored or coauthored more than 250 refereed journal articles, books, book chapters, and abstracts. His early research contributions concerned crowding and the effects of severe and chronic stress on health, best exemplified by his work after the Three Mile Island nuclear accident. More recently, Dr. Baum's work focused on the biobehavioral aspects of cancer and chronic illness, chronic stress and illness, psychoneuroimmunology, and molecular effects of stress and trauma.

Tracey A. Revenson is Professor of Psychology and Deputy Executive Officer at the Graduate Center of the City University of New York, where she is also a member of the Women's Studies Certificate Program. She holds a BA from Yale University and an MA and PhD from New York University; she completed a postdoctoral fellowship in environment, development, and health at the University of California, Irvine. Trained as a one of the first generation of health psychologists, she brings a socioecological perspective to her research on stress and coping processes among individuals, couples, and families facing chronic physical illnesses. She has also examined the influence on interpersonal relationships and gender on adaptation to illness. She is the author or editor of seven volumes, including *Couples Coping With Stress: Emerging Perspectives on Dyadic Coping* (APA Books, 2005), *Ecological Research to Promote Social Change* (Kluwer Academic, 2000), and *Social Categories in Everyday Life* (APA Books, 2011). She was the founding editor-in-chief of the journal *Women's Health: Research on Gender, Behavior and Policy*. She currently serves as associate editor of the *Annals of Behavioral Medicine* and is on the editorial board of *Health Psychology*. Dr. Revenson was elected president of the Division of Health Psychology of the American Psychological Association in 2004–2005.

Jerome E. Singer was Emeritus Professor, Department of Medical and Clinical Psychology, at the Uniformed Services University until his death on April 21, 2010. As chairman of this department from 1974 to 1999, he founded one of the first health psychology departments and, along with Andrew Baum, one of the first health psychology doctoral programs in the United States. Dr. Singer received his PhD at the University of Minnesota, where he conducted groundbreaking work on emotion with Stanley Schachter, and then held faculty positions at Pennsylvania State University and Stony Brook University. Dr. Singer received numerous honors, including an honorary doctoral degree from the University of Stockholm and the Award for Outstanding Contributions to Health Psychology from the Division of Health Psychology of the American Psychological Association (APA). He served as president of the Division of Health Psychology (38) of the APA in 1981–1982 and of the Academy of Behavioral Medicine Research in 1990–1991. Dr. Singer authored numerous articles and edited numerous books in the areas of stress and health psychology. Along with David C. Glass, he was awarded the Socio-Psychological Prize from the American Association for the Advancement of Science for their monograph *Urban Stress: Experiments With Noise and Social Stressors* (Academic Press, 1972).

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Introduction

Progress, Premises, and Promises of Health Psychology

Tracey A. Revenson

During the past four decades, health psychologists have worked to understand the biological, psychological, and social factors that affect health, health behavior, and illness. Researchers have grappled with probing questions: How do personality and behavior contribute to the pathophysiology of cardiovascular disease? What do women gain from screening mammography if it creates anxiety and avoidance of regular screening? Why do we expect individuals to take responsibility for condom use to prevent HIV transmission when using condoms is an interpersonal negotiation? When are social relationships supportive, and when are they detrimental to health? The chapters in this volume address these and many other questions (for these four questions, see Aiken, Gerend, Jackson, & Ranby, [Chapter 6](#); Antoni & Carrico, [Chapter 33](#); Betensky, Glass, & Contrada, [Chapter 27](#); Smith, Gallo, Shivpuri, & Brewer, [Chapter 17](#); and Wills & Ainette, [Chapter 20](#)). The field of health psychology has amassed a body of knowledge that has been—or has the potential to be—translated into clinical and community interventions to improve physical health and emotional well-being.

The discipline of health psychology brought together psychologists from traditional areas of psychology who shared a common interest in problems of health and illness but who brought their own disciplinary paradigms and methodologies to the table. Not surprisingly, this cacophony of models, approaches, methods, and jargon appeared confusing at times, raising the question of whether health psychology has its own paradigms (Friedman & Adler, 2007). That question remains unanswered, although many theories or minitheories exist (see [Section I](#), this volume). At the same time, this cacophony brought a breadth and eclecticism to the study of health–behavior relationships that has been partly responsible for its success as a subdiscipline within U.S. and European psychology.

The original paradigm adopted by health psychology was the *biopsychosocial model* (Engel, 1977; Schwartz, 1982), which posited that physiological, psychological, and social factors are braided together in health and illness processes and cannot be studied in isolation. Contrasting itself with biomedical models, the biopsychosocial model did not give primacy to biological indices, stating that it was impossible to understand disease processes without understanding the psychological mechanisms propelling them or the social context surrounding them. The biopsychosocial model was inclusive enough to be applied to risk estimates for particular diseases as well as health-promoting behaviors and environments, to disease progression as well as psychosocial adaptation to illness, and to individually oriented therapeutic and behavior change interventions as well as broader community-based and media approaches. The biopsychosocial model stimulated theories, research designs, and methods. Most important, it suggested a multicause, multieffect approach to health and illness, rather than the limiting single-cause, single-effect approach. However, there remained a compartmentalization of the components of the biopsychosocial model in the early years of the field in part because most health psychologists had been trained in the traditional areas of psychology (e.g., clinical psychology, social psychology).

The march toward middle age marks a good time to take stock of accomplishments and achievements, to do a little soul searching, and to make midcourse adjustments. Where is the field of

health psychology now? What has changed in the past decade, since the original publication of this handbook, and where is the field headed in the next decade? I offer a number of broad insights into the field and invite the reader to look for specific examples within the rich offerings of this handbook.

STABILITY AND CHANGE

Many of the original phenomena of interest in health psychology have remained central to the field over the past 40 years. The topics of stress and coping, health behavior change (including smoking cessation, condom use, and exercise), and cognitive models of why individuals do or do not engage in preventive health behavior (such as screening or treatment adherence) remain important areas for study (see Aiken et al., [Chapter 6](#); Brassington, Hekler, Cohen, & King, [Chapter 16](#); Dunbar-Jacob, Schlenk, & McCall, [Chapter 12](#); Glanz & Kegler, [Chapter 5](#); Grunberg, Berger, & Starosciak, [Chapter 14](#); Hoyt & Stanton, [Chapter 10](#); and Revenson & Lepore, [Chapter 9](#)). Because the work in these areas has grown, bringing in new models and methods and broadening the models to include more diverse populations, researchers working in these areas continue to make steady progress with the potential for translation to practice.

At the same time, much has changed in a decade. Some theories, among them the commonsense model of illness (Leventhal et al., [Chapter 1](#), this volume), have undergone substantial revision. Other theories have expanded in new directions and become more complex, particularly those that address behavior change (Glanz & Kegler, [Chapter 5](#), this volume). For example, in the area of stress and illness, we have moved far beyond correlations of the accumulation of self-reported stressful life events with reports of illness or medical visits to demonstrating causal pathways of stress with infectious disease (Marsland, Bachen, & Cohen, [Chapter 31](#), this volume). Similarly, in the understanding of pain, we have models that integrate physiology and psychology (Turk, Wilson, & Swanson, [Chapter 7](#), this volume); but also, with new methods and statistical techniques (e.g., a combination of daily process methods and hierarchical linear modeling), we can examine the causal role of emotions or social support in pain perceptions and coping behavior over time (e.g., Holtzman & DeLongis, 2007).

EXPANDING LEVELS OF ANALYSIS

There are two ways in which new approaches, perhaps better described as paradigmatic world-views, have come into health psychology. Both involve expanding the scope of the work to cross multiple levels of analysis. Anderson (1998) described a framework for health sciences that involve the need to study multiple levels of analysis of any health problem. These levels were the social/environmental, behavioral/psychological, organ systems, cellular, and molecular. More important, he indicated that the great advances would occur not with research that examines the association of variables within levels but with research that focuses on reciprocal and mutually causative processes between levels. At the time, much of health psychology research involved examining how a single variable, or multiple variables within a single level, affected health outcomes in an additive fashion. Anderson urged health psychologists to examine interactions among variables from at least two different levels of analysis to move the field of health psychology forward. [Chapter 19](#) in this volume, by Dunkel Schetter and Lobel, provides an excellent example of research that crosses multiple levels of analysis.

In the past decade, we have seen many examples of such movement. These movements have occurred in two different ways. The first is a centrifugal move inward toward the original “center” of biological and microanalytic processes (Jennings & Egizio, [Chapter 2](#), this volume). An example of this is how stress is implicated in infectious processes (Marsland et al., [Chapter 31](#), this volume). Contemporary research examines the pathways through which stress perceptions affect infection on organ system, cellular, and molecular levels (Dougall & Baum,

[Chapter 3](#), this volume; Miller, Chen, & Cole, 2009). As an exemplar of this research, Epel et al. (2004) demonstrated that among women facing chronic stress as well as women facing “normal” stress, greater perceived stress was associated with the biological indicators of accelerated cellular aging (telomere length, telomerase, and oxidative stress).

The second advance is a centripetal force that moves health psychology outward toward the social/environmental level of analysis. Health psychologists have taken the lead in examining the biological and psychological mechanisms by which socioeconomic status (SES) affects both individual and community health outcomes (Ruiz, Steffen, & Prather, [Chapter 23](#), this volume). For example, Matthews and Gallo (2011) have proposed a “reserve capacity model” to explain how individuals at the lower ends of the socioeconomic ladder may lack the resources to cope with many of the strains and stresses of everyday life, thus making them more vulnerable to illness. Similarly, moving away from simplistic models of race differences, psychologists have examined how perceptions of racism can affect cardiovascular reactivity and heart disease, specifying mediating mechanisms at multiple levels, including everyday racism, coping, and community norms (Brondolo, Lackey, & Love, [Chapter 24](#), this volume).

Another notable change is studying health–behavior processes within the social contexts in which we live: within the context of the family (see this volume, Alderfer & Stanley, [Chapter 21](#); Martire & Schulz, [Chapter 13](#); Revenson & Lepore, [Chapter 9](#)); within ascribed social roles (Helgeson, [Chapter 22](#), this volume); and within cultural communities that have received little prior attention by health psychologists (Mays, Maas, Ricks, & Cochran, [Chapter 34](#), this volume; Meyer, [Chapter 25](#), this volume). Health psychology has done a better job of including aspects of the larger sociopolitical context in models, such as social class (Ruiz et al., [Chapter 23](#), this volume), race and racism (Brondolo et al., [Chapter 24](#), this volume) and prejudice (Mays et al., [Chapter 34](#), this volume; Meyer, [Chapter 25](#), this volume). A contextual approach also recognize the fact that health-behavior processes are developmental and that we must understand health and illness processes at different stages of the life cycle (Siegler, Elias, & Bosworth, [Chapter 26](#), this volume). If this handbook is a reflection of the current state of the field, then health psychology research is currently represented at the intersections between all five of Anderson’s levels of analysis.

A FOCUS ON HEALTH AND ILLNESS

Despite its name, health psychology tended to focus more on diseases and disease outcomes instead of health. As shown in the chapters in [Section III](#) of this volume, this has changed radically over the past decade, with a balancing of risk and resilience factors in the prevention of illness as well as a focus on positive indicators of adjustment to illness. For example, there has been growth in the scientific inquiry into the benefits of spirituality, religion, and meaning making as predictors of overall health and well-being and of adjustment to stress and illness (Masters & Spielmans, 2007; Park, [Chapter 18](#), this volume). Adjustment outcomes involve such positive outcomes as stress-related growth and richer interpersonal relationships as well as such negative outcomes as depression and lowered quality of life (Hoyt & Stanton, [Chapter 10](#), this volume; Park, Lechner, Antoni, & Stanton, 2009; Stanton & Revenson, 2011).

This focus on health as well as illness has occurred in other areas as well. There has been an explosion of research on physical activity and exercise because they maintain health, prevent illness, and speed recovery (Brassington et al., [Chapter 16](#)). The field has gone beyond descriptive and correlational research on such stress buffers as social support and dispositional optimism to understanding the mechanisms for these relationships (Scheier, Carver, & Armstong, [Chapter 4](#), this volume; Wills & Ainette, [Chapter 20](#), this volume); prospective studies add causal strength to these explanations.

In addition to understanding the mechanisms by which disease can be prevented, researchers have made great advances in understanding those factors that optimize quality of life for people living with pain and serious illness (see this volume, Danoff-Burg & Seawell, [Chapter 32](#); Hoyt &

Stanton, [Chapter 10](#); Turk et al., [Chapter 7](#); see also [Section V](#), this volume). We now understand in a more sophisticated fashion how others in our social world can help or hinder our coping (see this volume, Alderfer & Stanley, [Chapter 21](#); Martire & Schulz, [Chapter 13](#); Revenson & Lepore, [Chapter 9](#); Wills & Ainette, [Chapter 20](#)); whether (and how) disclosing our emotions makes us feel better (Revenson & Lepore, [Chapter 9](#), this volume; Smyth, Pennebaker, & Arigo, [Chapter 8](#), this volume); and in an understudied area within health psychology, how sexual function affects quality of life (McClelland, [Chapter 11](#), this volume).

NEXT STEPS

There are a number of areas where progress has been made, but more needs to come. First is the area of behavioral interventions. The stellar research in many areas of health psychology holds great promise for translation into effective behavioral medicine interventions at both the clinical and community levels. The final section of this volume contains chapters that assess the state of the science in behavioral interventions for people with cardiovascular disease (Newman, Hirani, Stygall, Fteropoulli, [Chapter 28](#), this volume) and cancer (Faul & Jacobsen, [Chapter 30](#), this volume). Although many pilot projects suggest fruitful new directions, the findings from large-scale randomized clinical trials have been more equivocal (Coyne, Lepore, & Palmer, 2006; Schneiderman & Orth-Gomér, [Chapter 29](#), this volume; Wing & Phelan, [Chapter 15](#), this volume).

A second area where growth is needed is what is often referred to as “health disparities.” Health disparities are “differences in health that are not only unnecessary and avoidable, but in addition, are considered unfair and unjust” (Whitehead, 1992, p. 433). Health disparities research seeks to measure and reduce or eliminate avoidable differences in health. Most of the research on health disparities within health psychology, as in other disciplines, involves demonstrating between-group differences in some health indicator, most often between groups that differ in race or SES and occasionally in groups that differ in gender or gender orientation. However, between-group studies based on such nominal categories as ethnic-group membership do little to illuminate the mediating pathways that explain these group differences and may suggest loci for intervention (Yali & Revenson, 2004). Moreover, research on racial or gender disparities does not lead us to those answers when it is confounded with poverty or SES on either the individual or neighborhood level. Similarly, poverty does not fully account for race differences in health; these differences occur at every level of the SES gradient (Mays, Cochran, & Barnes, 2007). Our understanding of health disparities, as well as our ability to close the gaps, will increase if we consider the psychological manifestations of such group difference as racism, sexism, heterosexism, and ageism. For example, a number of studies have found that African Americans who attributed interpersonal mistreatment to racial discrimination exhibit greater blood pressure reactivity and recovery to laboratory stressors that bear similarities to an encounter with racial prejudice (Brondolo et al., [Chapter 24](#), this volume); these findings suggest that it is not race per se but perceived racism that may act as a chronic stressor. Similarly, place of birth, years in the United States, and acculturation level are often overlooked when racial health disparities are examined, but they are important moderators along with SES (Adler & Rehkopf, 2008). Including these multiple influences may help explain paradoxical effects in ethnic-minority populations, for example, why Latinas have worse health relative to non-Latino Whites but have lower all-cause mortality rates (e.g., Abraído-Lanza, Chao, & Flóres, 2005).

No individual-level factors (e.g., coping) have emerged as effective for offsetting the impact of racism on health (Brondolo et al., [Chapter 24](#), this volume). It is likely that changes will need to occur at structural, economic, and political levels in order to have the broadest impact on reducing health disparities. In a comprehensive review, Mays et al. (2007) describe several race–discrimination–health pathways that lead to poorer health, including segregation, residential stratification, conditions of violence, lack of social capital, and growing up in poor neighborhoods; Mays’ chapter in this volume ([Chapter 34](#)) lattices together race, discrimination, geography, and

politics to help us understand the HIV epidemic among African American women in the Southern United States. It cannot hurt to reiterate that health psychology will need to include social structural variables more directly into its research to be able to provide answers to these social health problems.

Recognizing the need for structural variables leads to the final point: The next generation of health psychologists needs to be trained to conduct interdisciplinary research and have a tool kit of multiple methods. It may benefit us to bring in the paradigms and methods of such sister fields as medical sociology and medical anthropology, as well as epidemiology and public health, to a greater degree in order to look more broadly and deeply across levels of analysis. Doing so will also move the field forward to be more accepting of multiple methods, including qualitative studies. At the beginning of a program of research or at the end, when research findings seem counterintuitive, qualitative research can not only help frame research questions but can also tell us whether we are asking the right questions. In a study that this author consulted on, the investigator wanted to know why African American women had much lower smoking cessation rates and much higher attrition rates in a behavioral counseling and medication intervention than did White women or Black or White men. Conducting a series of focus groups with women who dropped out of the trial, we learned that the Black women did not understand that the National Institutes of Health protocol stipulated that if they smoked even one cigarette, missed one counseling session, or failed to take the medication even one day, they would be dropped from the trial (Thompson, Revenson, & Covey, 2004). Not surprisingly, the women were outraged about the way they had been treated because this information had not been presented in an understandable fashion. Moreover, more African American than White women experienced physical side effects from the medication, which led to medication nonadherence. These qualitative data provided insight into the quantitative differences found and also suggested culturally sensitive changes for the next trial.

CONCLUSION

The exponential growth in brain and behavioral sciences over the past decade is mirrored in the field of health psychology. But rapid growth also begets growing pains. Health psychologists have taken stock, many times, to assess our progress and our pitfalls (e.g., Folkman & Moskowitz, 2004; Taylor, 1987, 1990). This introduction has served both to document the progress that the field of health psychology has made in the past decade and to suggest directions for greater impact. As Revenson and Baum (2001) quoted in the introduction to the first volume, “There are many miles to go before we sleep” (Frost, 1923). We continue to march forward.

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Section I

Overarching Frameworks and Paradigms

1 Modeling Health and Illness Behavior

The Approach of the Commonsense Model

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The current chapter updates and reorganizes our earlier handbook contribution, “Representations, Procedures and Affect in Illness Self Regulation” (H. Leventhal, Leventhal, and Cameron, 2001). The changes are a product of our insights into what the common-sense model (CSM) is now telling us and was telling us throughout its history. The CSM has undergone a number of changes in name reflecting the evidence and insights into the mechanisms underlying response to health information. The earliest version, the parallel processing model (H. Leventhal, 1970), emerged from studies of fear communications. The data from these studies showed that cognitive information and affective information were processed as separate, interacting meanings and feelings that affected immediate and delayed response to warnings of threatening health events. The fear studies and the descriptive and experimental studies of preparation for and response to stressful interventions—for example, such medical interventions as endoscopy (Johnson & Leventhal, 1974), such natural but stressful processes as childbirth (E. A. Leventhal, Leventhal, Shacham, & Easterline, 1989), and laboratory tests examining responses to the cold pressor (Ahles, Blanchard, & Leventhal, 1983; H. Leventhal, Brown, Shacham, & Engquist, 1979)—indicated that procedures and action plans, the nondeclarative knowledge involved in self-regulation, were separate from the cognitive representations and emotional reactions to stressful events. These data led us to change the model’s name from “parallel processing model” to “self-regulation model” to emphasize the focus on the performance components (perceptions and action plans) of the system. Finally, as we and many other investigators identified the cognitive contents and processes that guided how patients managed chronic conditions in their home environments, we recognized that a patient’s cognitive *representations* of a condition and its treatment provided the frameworks guiding everyday management. The cognitive emphasis led to a mix of renaming, including “model of illness cognition” (Croyle & Barger, 1993), “mental representations in health and illness” (Skelton & Croyle, 1991), and “common-sense representation of illness danger” (H. Leventhal, Meyer, & Nerenz, 1980). In sum, the name changes reflect the

evolution of the CSM as a framework for understanding how people adapt to health threats in settings ranging from hospitals to clinics and the home.

The CSM identifies variables, constructive processes, and behaviors that reflect how people in these settings perceive, understand, react to, and interact with others in managing threats to health. Although the concepts and processes articulated in the CSM are situated in a particular set of contexts, they are applicable to a wide range of life situations because health, illness, and dying are universal. Thus, the processes underlying how people represent and respond to health and illness in these settings reflect fundamental properties of the human mind and fundamental properties of the processes involved in sharing information when interacting with others. We view the CSM as a work in progress, that is, as a framework for conceptual elaboration and empirical work; it is not a closed system. A basic aim of this chapter is to show how a cognitive approach to health and illness behavior can be elaborated and used as a tool for the development of interventions in clinical settings to improve health outcomes.

The CSM is consistent with a long-standing tradition in social and personality psychology (e.g., Kelly, 1955; Lewin, 1935), as well as in studies of “folk illness” by medical anthropologists (e.g., Kleinman, 1980; Pachter, 1993). As is the case with the CSM, the variation in these names reflects differences in emphasis on various features of perception and action to prevent, treat, cure, and/or adjust to acute or chronic conditions. Three themes are fundamental to all these models:

1. Individuals are conceptualized as active problem solvers trying to make sense of potential or existent changes in their somatic state and to act to avoid or control those changes that are perceived as signs of illness or physical disorder; in effect, individuals are self-regulating systems. In this framework, adaptation is a product of a problem-solving process in which decisions to take one or more specific actions are based on the individual's understanding of the illness threat (*illness representations*), the availability of procedures for management (*representation of procedures and action plans*), and the experienced outcomes contingent on the costs and benefits of specific procedures.
2. The adaptive process is based on beliefs, commonsense perceptions, and available skills. That is, the representation of a disease threat, the representation of the procedures selected for its management, the plans for action, and the appraisal of outcomes are products of the individual's understanding and skills at a given point in time. Thus, neither the representations nor the procedures for management reflect the objective, biomedical nature of the threat or the procedures medically optimal for control.
3. The notion of folk illness, which distinguishes the biomedical concept of disease from the social concept of illness, emphasizes the role of the sociocultural environment in shaping the self-regulation process. Thus, an individual's representation of a threat and selection and evaluation of procedures for management are shaped and moderated by the attitudes and beliefs of his or her social and cultural environment. This environment includes family, friends, biomedical as well as traditional health practitioners, mass media, such socially defined roles as the passive versus active patient, and the linguistic terms used to label and describe specific diseases and treatments. Each of these factors constrains and shapes the substance and behavior of the self-regulation system. Because a wide range of factors shape the content, or *software*, of the self-regulatory behavioral system, assessments across persons within a common sociocultural domain and assessments across cultural domains will reveal both common and unique features of illness representations, coping strategies, and appraisals.

The themes enumerated in the preceding list are visible in each of the sections of this chapter. [Section 1](#), “The Content and Structure of the Commonsense Model,” provides an overview of the hierarchical structure of the CSM. It begins by describing the core control unit of the system, comprised of the representation of illness (its five content domains) and the representations of procedures and action plans for the implementation of action. The structure of each component is bilevel,

abstract, and perceptually and procedurally concrete. The representations and action plans of the core control unit are engaged in the more or less implicit, or automatic, management of illness and health problems. [Section 1](#) ends with a brief overview of the executive system and the tools it has for monitoring and regulating the behaviors generated by the core control unit.

[Section 2](#), “The Dynamics of Commonsense Self-Regulation,” describes the workings of the self-regulatory system, beginning with the detection of deviations from the normal, “healthy” self, and the matching of detected deviations to illness prototypes. The match activates the illness and treatment representations, or *hypotheses*, that control the problem-solving process. The focus here is on the rules governing the interactions among the system’s perceptual, cognitive, and affective components as individuals construct representations of threats and procedures for threat control. The self-system is central to our discussion of system dynamics because the meaning of specific illness episodes arises from their impact on the self.

[Section 3](#) briefly examines the ways in which the CSM has been used in interventions and in the construction of clinical trials. It also provides a brief overview of the CSM approach to the cultural and social context, with admittedly limited empirical examples. This section briefly examines ways in which the CSM addresses efforts at intervention and the construction of clinical trials. A possibly unique contribution of the CSM is the identification of specific elements involved in interpersonal exchanges that affect the construction of illness and treatment representations and the criteria patients use for testing the validity of their common-sense models. This approach complements social learning models of interpersonal influence.

Finally, [Section 4](#) offers some final points on the model, the premises underlying the CSM, and the implications of the CSM for reliability of instruments and clinical trials. The reader should be advised that our citations of the literature are selective and cover but a fraction of the diverse empirical literature relevant to the CSM approach to self-regulation. Older, exhaustive reviews are available elsewhere (Petrie & Weinman, 1997; Skelton & Croyle, 1991).

THE CONTENT AND STRUCTURE OF THE COMMONSENSE MODEL

In this section we review the content and structure of the CSM and supporting empirical evidence. The CSM’s architecture is hierarchical, with a feedback control system at its base, the executive system at the top, and strategies at intermediate levels. Although all systems are involved in generating behavior, not all are equally salient at a given moment. For example, the base-level control system is dominant for behaviors that are well practiced and relatively automatic, whereas the executive system exerts stronger control when behavior is interrupted and undergoing restructuring. The following four parts of this section cover the content and structure of the system: (1) The Core Control Unit, a feedback loop at the center of problem solving; (2) Illness Representations, Content, and Structure; (3) Procedures, Action Plans, and Appraisals: The Output/Performance Side of the System; and (4) The Self-System: Executive Function and Executive Tools. Any sequence we might choose for describing the system does violence to its operation because the system is not linear; however, because language is linear, we have no choice but to follow a linear sequence.

THE CORE CONTROL UNIT: A FEEDBACK LOOP

The majority of models describing self-regulation to health threats (e.g., Carver & Scheier, 1982; Lazarus & Folkman, 1984; H. Leventhal, 1970; Prochaska, DiClemente, & Norcross, 1992) contain a core feedback control unit that has the following properties: First, it is focused on ongoing self-regulation processes, that is, on *episodic problem solving*. Second, the problem-solving process involves at least three sets of factors: (1) a *representation* of the health problem that is active during the ongoing episode; (2) *procedures and action plans* for controlling the threat; and (3) an *appraisal* of the consequences of the coping efforts. The separation of the representation of the health threat from the procedures and action plans for threat management was a critical feature in

the earliest version of the CSM, the parallel processing model (H. Leventhal, 1970). The separation emerged from the repeated finding that messages depicting health threats did not lead to behavior unless they were combined with information suggesting a concrete plan for action. This finding held whether it was the simple act of taking a tetanus shot (H. Leventhal, Jones, & Trembly, 1966; H. Leventhal, Singer, & Jones, 1965) or the more complex act of quitting smoking (H. Leventhal, Watts, & Pagano, 1967). Neither the representation of the health threat (the fear message) alone nor the action plan alone produced action; the combination was essential. These factors—that is, representations, procedures for action, and the appraisals generated by postresponse feedback (a factor not examined in our earlier studies)—are the basic constituents of a TOTE (test-operate-test-exit) unit in control theory (Carver & Scheier, 1982; Miller, Galanter, & Pribram, 1960). The TOTE is, however, a content-free control unit; it can describe such a closed system as a thermostat to regulate heat or the control unit for managing threats to health. The latter is rich in content, open, and accessible to influence by higher order regulatory processes or executive functions. Anticipating our examination of system dynamics, we can expect that representations of threat and the action plans are likely closely interrelated and less independent of one another than is suggested by the stages in the early parallel response model, as shown in Figure 1.1.

Figure 1.1 depicts another important feature of reactions to health threats, namely, the parallel, or independent, processing of information for *controlling danger* and the processing of information for *controlling the emotional responses* elicited by the danger. The separateness of the two processing systems was visible in data showing that such vivid depictions of disease threats as films of surgery for lung cancer and photographs of the contortions of tetanus aroused stronger reports of fear and larger changes in attitudes than such less threatening depictions as risky driving (H. Leventhal & Trembly, 1968). The increase in fear and more favorable attitudes elicited by the strong fear messages were, however, transient and increasing the level of fear did not increase behavior (i.e., getting a chest x-ray or a tetanus shot). By contrast, if the fear messages were combined with an action plan, exposure to either strong or weak fear messages increased reported adherence to efforts to reduce smoking and recorded receipt of tetanus shots over the following weeks and months.

Efforts to understand how fear affects attitudes and behavior have, however, produced varied results. Some studies support the hypothesis that fear facilitates behaviors to prevent disease and inhibits behaviors to detect or approach a disease threat (Millar & Millar, 1996), but more recent work suggests that fear promotes adherence to both types of behavior (Diefenbach, Miller, & Daly, 1999). The findings from the early fear communication studies should not, however, be interpreted

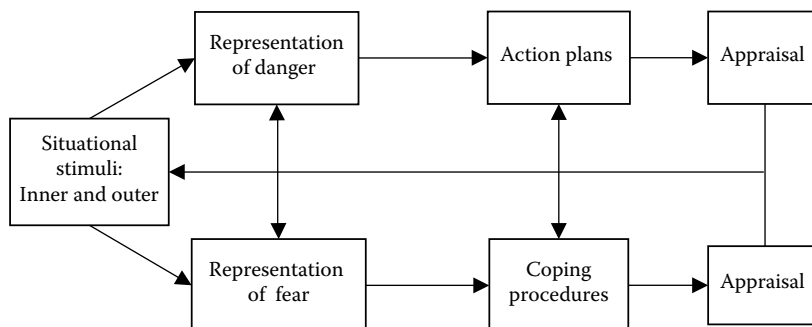


FIGURE 1.1 The parallel processing model. The model posited that two independent, interacting systems processed cues of health threats. The top row represents the cognitive system (i.e., what patients see, feel, and believe), which leads to action plans and action and then to a postaction appraisal. The lower row represents the emotional system (i.e., the experience of emotion), procedures for coping with emotion, and appraisal of coping outcomes. The representations of danger and fear are generated by informational antecedents different than action plans. The diagram is a highly simplified version of the model. (Adapted from Leventhal, H., in *Advances in Experimental Social Psychology*, 5, 176–177, Academic Press, New York, 1970.)

as inconsistent with these more recent data. Given the complexity of the system underlying the CSM, fear can have diverse effects on behavior depending on how it is related to the perceptual/cognitive and procedural/performance factors in the system. Thus, when fear is classically conditioned to perceptual cues to create so-called hot cognitions (Loewenstein, 2005), its consequences will be longer lasting and can drive behavior in different directions depending on the relative strength of procedures and action plans available for directly confronting the threat as opposed to those available for controlling fear (H. Leventhal, 1984; H. Leventhal & Scherer, 1987).

ILLNESS REPRESENTATIONS: STRUCTURE AND CONTENT

It is our contention that a psychological model of the processes involved in coping with specific illness episodes and illness threats must depict the structure and the content of the problem-solving system (the cognitive and emotional material within it). Although such a content-free model as the TOTE and its hierarchical versions (Austin & Vancouver, 1996) provide an approach to modeling dynamic systems, the absence of content is a serious limitation. Sociopsychological and cognitive research often ignores mental contents, seeing the task as secondary and of concern only to applied research. Content is ignored, however, at one's peril, for content affects both structure and process. The content (e.g., ideas about the indicators, duration, causes, and ways of preventing and curing specific diseases) is the software underlying everyday perception, thinking, and action (the commonsense system) and is a product of the individual's declarative and nondeclarative (perceptual and procedural) knowledge (Squire, 2004). The categories in which these common-sense ideas are cast (e.g., the attributes of illness representations, the perceptions and procedures in implicit and explicit awareness and memory, and the rules governing the behavior of the system) are constructions essential for describing and understanding the mechanisms underlying adaptive action (H. Leventhal & Nerenz, 1985). Ignoring structure and content is tantamount to ignoring nucleic acids, genes, proteins, and pathways in cell biology.

The CSM specifies the structure and content of representations of illness that provide the goals or targets for action and the specific procedures and action plans for performance and goal attainment in specific environments. Our approach to the identification of the content of illness representations was influenced by our decision to study illness behavior (Kasl & Cobb, 1966). The typical episode of illness behavior is initiated by somatic stimuli, that is, disease-related sensations (symptoms) and changes in function. Our objective was defined, therefore, as the investigation of the ways in which people understood and/or represented somatic and functional change and how the representations affected behavior (H. Leventhal, Nerenz, & Strauss, 1982; H. Leventhal & Leventhal, 1993). We assumed, incorrectly perhaps, that we would identify the same features of the representation of health threats whether we began our quest by studying how people interpreted somatic symptoms or by studying health-related actions that are undertaken in response to messages in media and/or the observation of illness in others by persons who are asymptomatic and presumed healthy.

The Content of Illness Representations

Open- and closed-ended interviews with patients and studies using multidimensional scaling of illness labels with undergraduates identified five sets of attributes of illness representations (see Figure 1.2): (1) *illness identity*, that is, the symptoms and labels that define the particular illness (Dempsey, Dracup, & Moser, 1995; Lau, Bernard, & Hartman, 1989; Meyer, Leventhal, & Gutmann, 1985); (2) *timelines*, including perceptions and beliefs respecting the onset, duration, and rate of decline with and/or without a home-based or medical intervention, as well as the time from disease onset to death when no treatment is possible (Heidrich, Forsthoff, & Ward, 1994; Meyer, Leventhal, & Gutmann, 1985); (3) *causes* of the threat, which may involve external agents (e.g., bacteria, viruses, job stress, or even bewitchment), internal susceptibilities (e.g., genetic factors), and behaviors (e.g., a lump causing breast cancer; Baumann, Cameron, Zimmerman, & Leventhal, 1989); (4) anticipated and experienced *consequences* of the disease, which may involve physical, emotional, social, and

economic outcomes (Cella, Tulskey, Gray, & Sarafian, 1993; Croyle & Jemmott, 1991); and (5) *control*, whether the threat to health is expected and perceived to be responsive to self and/or expert treatments (Lau & Hartman, 1983).

The five content domains of lay representations of illness have been written about from the time of Hippocrates and Galen to the present (Schober & Lacroix, 1991). The variables within these domains guide the selection of procedures for controlling disease and define the targets and time frames for observing outcomes. For example, the sudden onset of chest pain and breathlessness are likely to be experienced immediately as possible symptoms of a heart attack. Once the representation of a heart attack is activated, it will define the cessation of vigorous activities and rapid care-seeking as procedures for management of these symptom targets (Bunde & Martin, 2006; Matthews, Siegel, Kuller, Thompson, & Varat, 1983). Such symptoms as a lump in the breast or difficulty and pain during urination may activate representations of breast cancer and prostate cancer, respectively. The representations of these somatic changes may activate such procedures as “wait and see and test” (e.g., massage, drink fluids) before individuals seek a medical diagnosis (Cameron, Leventhal, & Leventhal, 1993; Facione, 1993; Hackett & Cassem, 1969). Symptoms represented as the “familiar common cold” are likely to become targets for a variety of self-care procedures as getting extra sleep, taking aspirin, taking vitamin C, and drinking fluid.

The Structure of Illness Representations

Representations have structure; they are both abstract and concrete. For example, such words as *cancer* and *heart attack* are labels for the abstract concepts that enrich the meaning of these diseases, and the symptoms and functional changes are their concrete, experienced features. Thus, the identity of a heart attack, cancer, or migraine headache involves an integration of abstract and experienced symptoms, the full or complete meaning of which involves abstract and concrete factors in the domains of timeline, consequences, perceived causes, and response to treatments (Andrews, Vigliocco, & Vinson, 2009). The multilevel nature of disease representations is a salient feature of physician-authors’ autobiographies of life-threatening illnesses (Mandell & Spiro, 1987) and is consistent with data showing that concrete experience (symptoms and functional change) are often the main drivers of behavior. For example, concrete, symptomatic experiences are consistent and powerful predictors of utilization of health care (Berkanovic, Hurwicz, & Landsverk, 1988; McKinlay & Dutton, 1974; Pescosolido, 1992). The more interesting examples of the abstract and concrete nature of representations are those in which behavior is a product of interactions among the levels. For example, using data from six large surveys conducted in Africa and Asia, Yoder and Hornik (1996) found that mothers used oral rehydration to treat infant diarrhea if they observed concrete symptoms (e.g., vomiting, fever, reduced play) and judged the child’s condition to be serious. Thus, concrete experience had direct effects as well as indirect effects (moderated by severity judgments) on behavior. Concrete experience is clearly critical in acceptance or rejection of injectable antiretroviral therapy for HIV (Horne, Cooper, & Fisher, 2008).

More dramatic evidence appears when abstract and concrete levels of processing generate conflicting goals and different criteria for appraising the efficacy of a procedure for illness management. These conflicts typically focus on differences in time frames. For example, when conditions are represented as acute, perceptual experience and the immediate effects of behavior on symptoms will control action. When a condition is represented as chronic, the time frame is abstract and lifelong and behavior is more likely to be initiated and evaluated by objective cues and indicators. Diabetes, hypertension, asthma, and cardiovascular disease provide examples of the conflicting approaches to management generated by the concrete and abstract levels of representation. Diabetic patients rely on symptoms to vary their insulin and food intake to avoid hypoglycemia even though they are trained to be active users of accurate, objective devices for assessing blood glucose levels; subjective cues often win the competition over objective indicators as guides for action (Gonder-Frederick & Cox, 1991). Hypertensive patients behave similarly. Meyer, Leventhal, and Gutmann

(1985) found that 80% of the patients in their study who were in ongoing treatment agreed with the statement that “people can’t tell when their blood pressure is elevated,” a response that recognizes hypertension as asymptomatic. However, 90% of these patients believed they could tell whether their blood pressure was elevated and named such somatic cues as heart palpitations, warm face, and headaches as valid indicators. More important, patients were compliant and had better blood pressure control if they believed their medications reduced their symptoms. If the medications were seen as ineffective in controlling symptoms, both adherence and blood pressure control were poor. It is likely that patients agreed with the “people can’t tell” statement because doctors told them that elevated blood pressure is asymptomatic or silent. Words can, however, be empty, not anchored in experience or action.

The belief that hypertensive disease is symptomatic is unsurprising on three counts. First, the label *hypertension* suggests that specific somatic experiences accompany elevated blood pressure (Blumhagen, 1980). Second, exertion and psychological stress can produce acute, phasic changes in blood pressure that generate palpable somatic experiences (Pennebaker & Watson, 1988). Third, medical practitioners may inadvertently suggest that hypertension is symptomatic when they conduct the standard, head-to-toe “review of systems” to detect comorbidities and unfavorable sequela of hypertension and its treatment.

That these factors link specific symptoms to the label *hypertension* reflects a fundamental feature of the cognitive system, namely, the need to anchor abstractions in concrete experience (Quinn & Eimas, 1997; Rosch, Mervis, Gray, Johnson, & Boyes-Braem, 1976). We initially conceptualized this linkage as a *symmetry rule*; that is, the experience of symptoms will lead to a search for labels, and the presence of labels will lead to a search for symptoms. The effect of symptoms on the search for labels was demonstrated by Schachter and Singer’s (1962) classic study of emotional contagion (1962) and is consistent with early studies showing that concepts with perceptual referents, or concrete concepts, are mastered more easily than abstract concepts (Johnson, 1975). The converse, that labels can stimulate a search for symptoms, was observed in a study where participants told that their blood pressure was elevated actually reported more symptoms, which were identical to those reported by hypertensive patients; symptom reports did not increase among participants given false feedback that their blood pressures were normal (Baumann, Cameron, Zimmerman, & Leventhal, 1989; Croyle, 1990).

A dramatic example of the impact of labeling on blood pressure was uncovered in a recent study of white-coat hypertension, which is the increase in blood pressure that some patients experience when a physician takes their blood pressure at a clinic (Spruill et al., 2007). To determine who was truly hypertensive, the 214 patients in the study were required to wear ambulatory monitoring devices for 36 hours; 119 patients proved to be hypertensive, with base-level blood pressure elevated during that time, whereas 95 were not. In each of these two groups were patients who incorrectly labeled themselves as hyper- or normotensive. The day after monitoring, patients returned to the clinic for evaluation and their blood pressure was taken by the physician. Readings were above ambulatory levels for the patients who believed they were hypertensive regardless of their actual hypertensive status. Thus, the self-characterization was related to the increase in readings and actual, ambulatory classification as hypertensive was not. Patients showing the white-coat effect also reported worry about their blood pressure. Both the elevated worry and the increased blood pressure were reactions specific to the clinic setting; neither worry nor elevated readings were related to the patients’ level of trait anxiety.

PROCEDURES, ACTION PLANS, AND APPRAISALS: THE OUTPUT/PERFORMANCE SIDE OF THE SYSTEM

The representation of a health threat creates the framework for action; the response output, or performance, requires the selection of a procedure and the formation of an action plan (Cioffi, 1991; H. Leventhal, 1970). In the CSM, illness representations define the threat and activate motivation for

action, identify procedures appropriate for control, define goals or targets for determining efficacy, and sustain performance until the threat is removed (H. Leventhal, Diefenbach, & Leventhal, 1992). For example, an individual suffering from a runny nose and a headache may assume that he has an acute cold (identity and symptoms), one that will last for a week (time frame), is uncomfortable but not life threatening (consequences), and whose symptoms can be managed (control). The representation sets the framework for the selection of such an over-the-counter medication as aspirin or acetaminophen (identity and control) to eliminate or reduce the symptoms in half an hour to an hour, to work for 4 to 6 hours (timelines) with no serious side effects other than stomach irritation, which can be controlled with an antacid (consequences). The representations of procedures for performance are shaped by and reflect the properties of the illness representations. The combination of the procedural representations with an action plan completes the performance, or output, side of the CSM control units.

Representations of Procedures

The variety of procedures available for the management of health threats is enormous. Procedures include such short-term actions as the use of over-the-counter medications, participation in procedures available for the early detection of cardiovascular disease and cancers, annual checkups, and surgery or other one-time repairs. In addition, the individual can engage in such longer term actions as adopting a low-fat diet, quitting smoking and maintaining cessation, adopting any number of lifetime procedures to minimize dysfunction, or living with a chronic condition.

The extraordinary variety of procedures for health maintenance and avoidance and the control of disease reflects the complexities of human biology and the cultural and social systems that have emerged in every known human population. In addition to their enormous variety and specificity, most procedures have multiple objectives; moreover, the very same procedure may have different objectives at varying points in time. Examples of multiple functions can be found for medications, physical activities, and social contacts. Insulin used to control blood glucose levels in diabetics has, for instance, been used to prevent cardiac complications among severely ill hospitalized patients who are not diabetic (Ellaham, 2010). Exercise can enhance endurance and coronary health, reduce depression, and slow and perhaps avoid dementia. Social comparison can assist in determining the cause of symptoms, clarifying expectations, and reducing fear. For example, if two people suffer from stomach pains, vomiting, and diarrhea 12 hours after sharing dessert at lunchtime, it is plausible to assume that both are suffering from food poisoning rather than to conclude they are dealing with an ulcer or stomach cancer (H. Leventhal, Hudson, & Robitaille, 1997). In addition, patients awaiting surgery are comforted if rooming with and able to view healthy survivors of treatment (Kulik & Mahler, 1997). Comparisons provide diagnostic insight and reassurance, depending, of course, on the status of the targets of comparison.

Procedures for appraising the efficacy of procedures for self-management are central to the CSM and to utility and social learning models. The factors most frequently mentioned are *response efficacy*, or the effectiveness of the response in meeting its goal, and *self-efficacy*, or the individual's belief in his or her ability to perform the response (Bandura, 1997). Both social learning theory and the CSM consider a much wider range of factors in the appraisal process than do other models. Here, anticipated and perceived efficacy are related to the magnitude of change achieved in the experience of concrete symptoms and in objective disease indicators, whether alone or in combination, along with unwanted side effects of the treatment (consequences) and timelines for effects.

The contrast between social learning and CSM approaches and models of coping is sharper still. The former focus on specific responses (e.g., taking a medication, endurance versus strength exercises), whereas studies of coping have focused on the identification and assessment of such broad classes of behavior as problem-focused coping and emotion-focused coping and have assessed these factors to predict behavioral and health outcomes (Lazarus & Launier, 1979). In the CSM, illness representations stipulate specific responses or specific classes of response for management

in specific settings. For example, if gastric distress is perceived to be caused by food, the representation will encourage the use of a tablet or liquid antacid; whereas if poisoning or recurrence of stomach cancer is the perceived cause, a visit to the emergency department or oncologist would be appropriate. All three responses—taking antacid, visiting the emergency department, and seeing an oncologist—are both problem focused and emotion focused because they resolve the defined problem and minimize associated affect. The CSM can predict response choice, whereas coping theory does not.

Such generic factors as problem-focused and emotion-focused coping, along with such factors as conservation of resources (Hobfoll, 1989)—that is, reduced activity designed to conserve energy (Duke, Brownlee, Leventhal, & Leventhal, 2002)—define the potential focus for behavioral management. Thus, these factors identify strategies that can moderate the selection of a procedure from among the set of procedures consistent with the illness representation. For example, the experience of breathlessness can encourage moderate exercise or block physical activity. The choice of a procedure can be moderated by the patient's strategy; if his or her strategy is to conserve resources and minimize symptom-induced fears, rest would be preferred over exercise. If the individual's strategy is to confront problems and strengthen the system through use (E. A. Leventhal & Crouch, 1997; H. Leventhal, Leventhal, & Schaefer, 1991), moderate exercise would be preferred. Hierarchical models, representations of illness and procedures for management nested under strategies, have been proposed to deal with moderators (Krohne, 1993; E. A. Leventhal, Suls, & Leventhal, 1993). The modest predictive power of coping instruments, the inconsistent outcomes from study to study, and the failure of coping theory-based interventions to improve adherence reflect the absence of solid empirical data on different levels of analysis. Exceptions will be mentioned later (see Stone, Helder, & Schneider, 1988; Stone & Neale, 1984).

Horne and his associates (Horne, 1997; Horne, Wienman, & Hankins, 1999) have examined the range of beliefs and perceptions that people hold respecting medications. These beliefs can focus on medications in general (Figueiras et al., 2009) or on the specific medications taken to manage a particular condition (Horne, 1997, 2003). For example, people may feel medications are necessary and beneficial while simultaneously expressing such concerns about medications as feeling they are overprescribed, are risky because they can be addictive, or have harmful side effects. When evaluating medications prescribed for themselves, patients hold a range of beliefs about what is necessary. Thus, their perceptions of what they need and the benefits they may reap from the medications they take may include beliefs about the best causal route for achieving benefits, a timeline for benefit, and the relief of symptoms as well as improvement in objective indicators, beliefs, and perceptions that underlie simpler notions of efficacy and self-efficacy in use. Beliefs in the need for and concerns about one's prescribed medication affect, for example, how patients managing HIV perceive and adhere to their life-saving medications (Horne, Cooper, Gellaitry, Date, & Fisher, 2007), how individuals adhere to antihypertensive medication (Horne, Clatworthy, Polmear, & Weinman, 2001), and how sufferers adhere to medication for inflammatory bowel disease (Horne, Parham, Driscoll, & Robinson, 2009). The variety, flexibility, and variation in functional utility of specific procedures are central to the CSM. In the CSM, procedures and action plans are the components that combine with illness representations to generate the behaviors that affect health outcomes.

Action Plans

Action plans are the central players for the implementation of procedures. Studies of fear communications indicate that action plans are essential for performance (H. Leventhal, 1970; H. Leventhal, Singer, & Jones, 1965). Action plans play multiple roles in the implementation process. The most obvious role, perhaps, is establishing a cue for behavior; for example, using breakfast as a cue to take a proton pump inhibitor and an antihypertension medication, or using the biggest meal of the day as a cue to take a lipid-lowering agent. Implementation intentions, the mediator between intentions and performance, are also defined by the cueing function (Gollwitzer, 1999; Sheeran & Orbell, 2000). The second and likely most important feature of an action plan involves optimal placement

of the cue in the individual's behavioral environment. For example, a patient who always drinks coffee or juice in the morning might place the medication near the coffee pot or juice carton; if liquids or breakfast are a sometime affair but tooth brushing or a mouth rinse is not, the medication should be placed in that context. Action plans must satisfy a third requirement to produce the biological effects desired with adherence: the time for use must consider the half-life of the medication in relation to the environmental context. For example, pantoprazole will be more effective in controlling acid production and lowering the probability of cancer from an esophageal ulcer if it is taken prior to the first meal of the day rather than at night. Creating an action plan to link treatment to an individual's life pattern can be a demanding and complex affair if the individual's work or life patterns are chaotic or if the individual lacks the cognitive competency to assist in designing an appropriate plan.

THE EXECUTIVE SELF: STRATEGIES AND TOOLS FOR FUNCTION

The control system, representations of illness and treatment, and action plans operate in the context of the self and its executive functions. The executive operates in three areas: monitoring the output of automatic subsystems, holding information in working memory, and regulating such behavioral processes as thoughts and overt behavior. Monitoring involves screening and selecting specific cues as targets for action and selecting criteria for evaluating behavioral outcomes. The executive uses a variety of processes to hold information in short-term memory for ongoing problem solving, organizes and rehearses material to ensure later recall when needed, and engages in other transformations of material to increase the availability of material for delayed use. Behavioral regulation involves scanning and selecting procedures or tools for responding to particular settings, modifying routines, and creating action plans.

The Prototype of Self

In addition to monitoring and regulating the monitoring, organizing and storing information, and shaping behaviors for problem solving, the executive plays a central role in evaluating the implications of current function, symptoms and illness, and treatment for future goals (Hooker & Kaus, 1994; Marcus & Nurius, 1986). That each of us possesses an underlying schema or prototype of the self is apparent from the large number of studies showing that self-assessments of health (SAH) are valid predictors of mortality. As global judgments of overall health status on a simple, 5-point scale, answering, "Would you say your health is excellent, very good, good, fair, or poor," health self-assessments predict mortality over time frames of 20 and more years in community samples and perform equally well in patients in clinical settings (Benyamini & Idler, 1999; Idler & Benyamini, 1997; Jylha, 2009). Symptoms and knowledge of existent medical conditions have been shown to be strong predictors of these self-assessments (Idler, Leventhal, McLaughlin, & Leventhal, 2004), but the factor most strongly related to SAH is function, that is, the ability to perform everyday tasks, the instrumental activities of daily life. Mora and colleagues (2008) found that reports of functional competence by elderly community-dwelling participants were the strongest predictors of mortality in the 5 following years, and declines in annual reports of functional competence over the 5 years were correlated close to .90 with declines in annual SAH over that same time frame. The combination of baseline SAH and the slope of the change in annual SAH were strong predictors of mortality. (Because of their high correlation, the slope of change in annual judgments of function could be used in place of SAH.) Recent studies found that self-assessments of health and current function predicted mortality among patients with terminal cancers and were, in fact, stronger predictors of mortality than available clinical indicators (Shadbolt, Barresi, & Craft, 2002; Teno, Weitzen, Fennell, & Mor, 2001).

In summary, the more than 200 community studies from different countries and the somewhat smaller but equally impressive number of studies of clinical samples provide incontrovertible

support for the assumption that individuals have access to subjective cues that provide valid evidence on the viability of their physical selves. The data stand in stark contrast to the studies on the validity of predictions based on affective states: predictions of future affect are notoriously inaccurate; and projections of future preferences, for example, for thirst (Van Boven & Loewenstein, 2003) or for treatment, are biased by current emotional states. Identification of the specific features of the self that inform SAH is critical for the elucidation of mechanisms underlying prototype checks that lead to the activation of illness representations and affect treatment decisions, including those made when terminally ill (Saraiya, Bodnar-Deren, Leventhal, & Leventhal, 2008). The evidence from the two very different sources, that is, clinical and community studies, converge in suggesting that functional changes are the critical inputs to self-assessments of health. Function, however, is a very broad category; and individuals may differ in the attention and weight they give to one or another functional change. The CSM also suggests that the weight given to a specific functional change may depend on the rate of decline: rapid declines tend to create a sense of urgency, and gradual ones tend to be attributed to general issues in aging. Filling in these details will be critical for understanding the dynamics underlying health and illness decisions. These will be discussed in greater detail in [sections 2 and 3](#).

Tools for Self-Management

Although much, if not most, monitoring of behavioral output, short-term information storage, and response modification occur automatically, these processes are shared and duplicated by executive processes. Executive-level monitoring (screening and target selection), outcome evaluation, and response control differ from monitoring, evaluation, and control at well-practiced, more automatic levels. Executive processes are slower, less detailed, more global, and more resource intensive than well-practiced, implicit processes. These differences are a necessary consequence of the executive position as a general problem solver. Borrowing from other cognitive models, the CSM hypothesizes that the executive requires generic tools and strategies for engaging and managing a broad array of automatic systems and environmental contexts. The cognitive tools or heuristics for managing changing somatic experiences and functional changes—for example, controlling the direction of attention, retrieving information that is “available” and “representative” (Tversky & Kahneman, 1974)—are not necessarily tuned or relevant to the condition at hand. Behavioral tools or heuristics (e.g., stop, step back and take another look, slow down, and monitor while rehearsing) are general strategies or tools and are not designed to fit a specific context; they are similar to the contrast between a variable wrench and one designed to fit a one-quarter-inch-diameter hexagonal bolt. We will discuss these processes in greater detail as we address the dynamics of common-sense regulation in the following section.

THE DYNAMICS OF COMMONSENSE SELF-REGULATION

Studies from the CSM framework have examined some of the processes underlying decisions and actions to control physical illnesses; these studies are an important contribution of the CSM for understanding self-regulation dynamics. We will describe findings in the following areas: (a) the construction of illness representations, a theoretically implicit and largely automatic process; (b) the interaction of executive and automatic processes for the selection of procedures for managing cardiovascular conditions; and (c) the assessment of the prototypes that underlie the constructive process (discussed in [section 1](#)).

Examining these dynamic processes provides a view of the interaction between the content and structure of commonsense models; it brings the system to life. Whether the findings are from cross-sectional or longitudinal data, they provide a single picture or a sequence of snapshots of the changing common-sense model at specific time points. We do not have a running, “online” view of the system’s operation. Despite this shortcoming, one can see how the system likely operates and can detect issues requiring further empirical study. Our view of the system can be described

in the following sequence: (a) the experience of somatic sensations and functions discrepant from the usual, normal self are detected automatically and matched either automatically (nonconscious) or deliberately (conscious) to underlying illness prototypes to form illness representations; (b) once these experiences enter awareness, either because they match a specific prototype to form a representation or because of increases in their intensity, duration, and disruptiveness, the executive functions of the self-system (ES) is engaged in self-examination and treatment; (c) if the condition increases in severity and duration or fails to respond to self-treatment, the ES will discuss the condition with someone close; and (d) medical care will ensue if the close other concurs with the self-expressed concern. The sequence is not linear, however. Individuals strongly predisposed to meditate, exercise, or seek medical care may respond to somatic cues far too subtle and vague to match a prototype of any specific illness and engage in these behaviors preventively, for example, exercising to get rid of a subtle sense of malaise that does not match the prototype of a specific illness.

Our review also highlights issues involved in the processing, selection, appraisal, and formation of action plans—part of the CSM dynamic process—that need further investigation. The first are the details of the “normal” prototype of the physical and functional self. The second is an examination of prototypes of illnesses. An examination of system dynamics makes clear that prototypes are not the same as representations of illnesses and treatments; prototypes underlie the activation of representations. Prototypes also play a critical role in the arousal of emotion; these processes will be discussed briefly. Finally, we will touch upon the need for increased understanding of the processes by which voluntary self-management routines are automated.

DETECTING AND MATCHING DEVIATIONS TO ILLNESS PROTOTYPES

In the absence of distractions, changes in somatic sensations and physical and cognitive functions enter awareness automatically (Pennebaker, 1999). When these sensations deviate from the normal or usual sense of self, they will be compared automatically and matched to one or another underlying prototype or schema (Bishop, 1991). When matched and recognized as an example of such a familiar experience as a stress headache, muscle strain, gastric distress, allergies, or a head cold, the condition will be perceived as acute and self-resolving (Bishop & Converse, 1986). The CSM will engage conscious, executive function to select and perform a procedure that is familiar and expected to be effective: a favorite home remedy, over-the-counter medication, or bed rest, for example. The time frames for the representation of the condition and the self-selected treatment establish a criterion for evaluating efficacy; thus, for example, a headache should go away in half an hour to an hour after taking aspirin or acetaminophen.

Deviations Can Activate Executive Decisions

When symptoms and functional changes exceed the threshold for disruptiveness or do not respond to usually effective self-management, the executive system is “wakened” to further action. An excellent example of this process is seen in Cameron and colleagues’ 1993 analysis of the factors leading to the use of medical care in a sample of 111 elderly individuals interviewed immediately prior to their seeing their primary care physician for a self-initiated visit. Not surprisingly, all 111 subjects reported experiencing new or worrisome symptoms. The overpowering role of somatic changes in initiating the visit was clear when these symptomatic care seekers were compared to control participants who had not sought care and were matched to them on age, gender, and family size. These matched control participants were called as soon as possible and asked how they were feeling and if they had any symptoms or functional problems; only 30% had a new or worrisome symptom, a difference of 70% and a clear example of the power of symptoms as initiators of care seeking. Symptoms alone are not, however, sufficient for care seeking; indeed, common sense suggests symptoms have to be painful or disruptive of daily function, fail to respond to self-management, or match to a prototype that activates a representation of a potentially threatening illness. The data supported these assumptions: relative to the representations of symptoms of the 111 care seekers,

the symptoms reported by the 33 symptomatic matched controls were rated as less serious and disruptive, of shorter duration, and less likely to be labeled as symptoms of a specific illness. In addition, control participants were less likely to have discussed their symptoms with another person, and those who did were much less likely to be advised to seek care. In sum, the representations of their symptoms were less fleshed out; neither the representations nor their efforts at control had crossed the border from minor deviations to potential threat. Deviations that are sufficiently severe and threatening, that is, deviations that cross a border (the crossing can be fear based and automatic or a deliberate decision), lead to discussion with others and care seeking, all complex processes in the domain of executive function.

Mora and colleagues (2002) replicated and extended Cameron et al.'s findings (1993) by comparing the magnitude of the relationship of personal traits and the attributes of the illness episode in the prediction of care seeking. Personal characteristics, including age, gender, illness burden, trait negative affect, and self-assessments of health, had no relationship to care seeking for either an acute condition or a flare of a chronic condition. By contrast, four characteristics of the unfolding episode were related to care seeking: number of symptoms, severity, duration, and novelty of the symptoms. As with the findings for white-coat hypertension, anxiety specific to the ongoing episode was a strong predictor of care seeking for ongoing chronic conditions, but trait anxiety was not.

Care seeking requires both the elaboration of key features of the representation and evidence of failure to manage or control symptoms. These studies suggest that the initial representation of somatic and functional changes as a familiar, benign event is fragile and readily disrupted if the ongoing changes last and are unresponsive to self-initiated action. The tendency to perceive events as acute is consistent with reality, given that most symptoms and dysfunctions are temporary, and consistent with the need to sustain optimistic expectations (Taylor, 1983, 1991). For example, 40% of the women entering chemotherapy treatment for metastatic breast cancer believed their disease equivalent to an acute, curable illness (H. Leventhal, Easterling, Coons, Luchterhand, & Love, 1986). This statistic is also true of chronic conditions that are less life threatening than cancer, such as asthma. The great majority of patients hospitalized with asthma believe they will have asthma all their lives, but over half also believe they have asthma only when symptomatic (Halm, Mora, & Leventhal, 2006). Patients whose asthma representations are modeled on the episodic nature of flares are less likely to use medication to prevent attacks, to be checked when asymptomatic, or to test pulmonary function and use results to modify medication dosages. Data also suggest that as symptoms decline and function appears to return to normal, the executive self tends to act as though all is well and self-regulation declines. Self-management can stop even when a patient agrees that he or she has such a chronic condition as asthma (Halm et al., 2006), has AIDS (Horne et al., 2004; Reynolds et al., 2009), or experiences myocardial infarction (Sambamoorthi, Moynihan, McSpirt, & Crystal, 2001).

Matching Experience to Prototypes Activates Illness Representations

If illness and treatment representations are generated from the matching and/or integration of experience with underlying prototypes, how does this matching occur? The CSM is specific about the matching process, identifying the elements involved in matching, suggesting the sequence in which they operate, and distinguishing which portions of the process are automatic and which remain under executive control. Empirical studies within the CSM framework (Bauman, Cameron, Zimmerman, & Leventhal, 1989; Bishop, 1991; Bishop & Converse, 1986), related investigations (Godoy-Izquierdo, López-Chicheri, López-Torrecillas, Vélez, & Godoy, 2007), and reviews (Brody & Kleban, 1983; Stoller, 1993, 1997) suggest that representations of illness and treatments, action plans, and overt action are activated by the match of experience to prototypes. Such diagrams as [Figure 1.2](#) are concordant with the suggestion that the process is often linear; that is, somatic and external stimuli generate illness representations that generate procedures implemented by action plans, the outcomes of which are appraised for efficacy. The CSM also includes two sets of reverse arrows, as shown in [Figure 1.2](#). The first identifies a feedback path indicating

that postaction feedback can alter any or all of the prior components, beginning with the stimulus inputs (symptom reduction), continuing through changes in dosing and selection of an alternative procedure, and then moving from self-management to expert assistance (solid, leftward pointing arrows). The second, dashed, leftward-pointing arrow defines a feed-forward path by which action plans or the availability of a procedure generates somatic stimuli and creates illness representations. A common example would involve the activation of vague somatic stimuli when thinking about the diagnosis or treatment of a threatening condition, as in the case of white-coat hypertension (Spruill et al., 2007). Pathways such as these are also seen in the “worried well” (Cameron, Leventhal, & Leventhal, 1995) and healthy individuals who seek care for cardiovascular disease (Aikens, Zvolensky, & Eifert, 2001; Bunde & Martin, 2006). These feed-forward pathways exist in many complex systems; however, their influence may be visible only in relatively small percentages of episodes and individuals. Because the traditional linear order is likely most common, we will begin by addressing the processes involved in the conversion of somatic stimuli to symptoms and illness representations.

Specific Elements Convert Sensations to Symptoms: The Matching Process

The ability to distinguish nonself from self, or pathogenic processes from normal and nonthreatening departures from baseline, is typically the initial step in the activation of illness representations. Lazarus (1966) has labeled the interpretive step of translating somatic sensations into symptoms “primary appraisal.” The word *appraisal* implies that decoding is a conscious process; this is unfortunate because much of the decoding process takes place automatically and implicitly, that is, outside awareness (Henderson, Hagger, & Orbell, 2007; Shiloh, Peretz, & Iss, 2007).

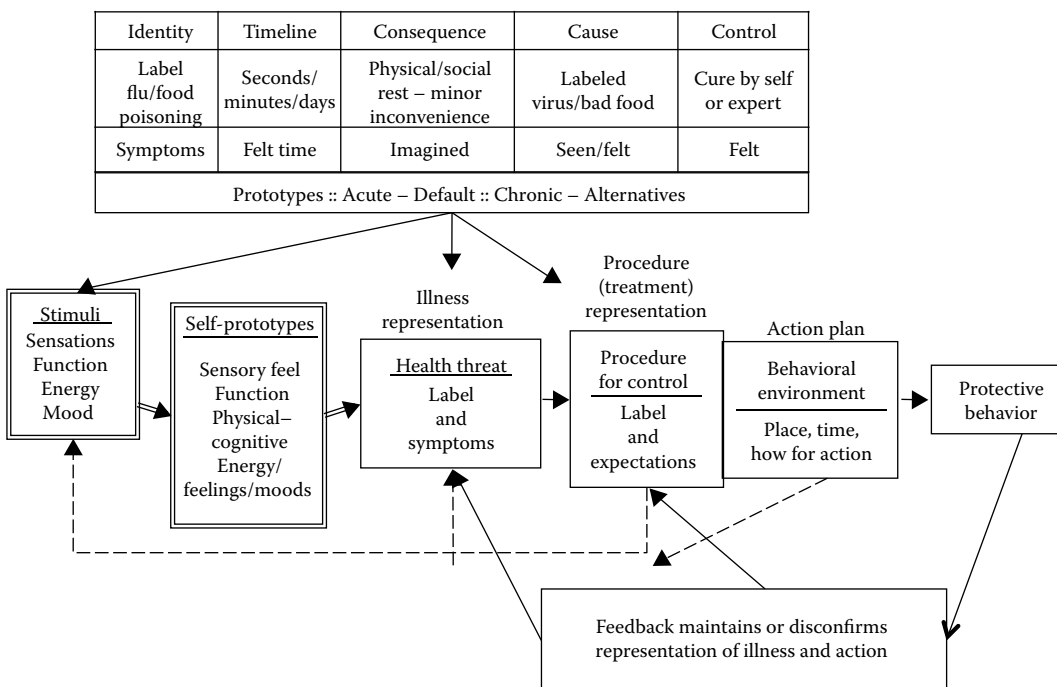


FIGURE 1.2 An early view of the CSM. Solid arrows identify pathways for rapid, relatively automatic processing from detection of deviations, through activation of a representation to feedback. The five domains of the representations affect the interpretation of cues, set targets and time frames for action and anticipated outcomes, and efforts to control perceived causes. Dashed arrows represent the effects of action readiness (procedures and plans) to searching for, detecting, and representing cues for action; this is a feed-forward pathway.

The data we have reviewed suggest three processes common to this early step. First, a somatic sensation or change in function will become a source of uncertainty and concern if it deviates significantly from the normal or healthy self, fails to match an existent prototype of an acute but benign condition, and interferes with daily functioning. Expert-care seeking is likely if the deviations are severe, long-lasting, unresponsive to self or family management, and distracting from everyday activities. These factors may also be accompanied by concern that the observed changes may match a chronic or life-threatening condition. Second, if the somatic sensations and functional changes match an illness schemata or prototype of a familiar, acute condition, the match is more rapid, even automatic, if all symptoms match the underlying prototype (Bishop & Converse, 1986). These rapidly formed representations activate treatment procedures embedded in well-learned action plans, making care seeking unlikely if home-based treatments alleviate the initiating discrepancy. Third, the deviations may quickly be matched to a serious, chronic illness (e.g., cancer, diabetes) or a life-threatening acute or episodic condition (e.g., heart attack or asthma).

Perceptual recognition is the initial process in each of the foregoing pathways: a deviation is perceived and represented automatically; or it is perceived, not definitively matched, and remains ambiguous. The prototype-check process does not require the use of abstract symbols or words. The word *headache* is not necessary to feel and recognize headaches any more than the word *table* is needed to see and recognize tables; recognition is automatic and further supplemented by self-involvement; for example, if resting one's arm on the table causes it to wobble, one may be reminded of earlier situations where a wobbly table created an embarrassing spill.

An array of expectations respecting causes, consequences, and the like, will come into play once the deviation is lodged in a prototype because prototypes are amalgams of declarative (semantic and episodic) and nondeclarative (perceptual and procedural) memories (Squire, 2004). Cognitive scientists have described this matching process in general terms, undefined elements linking experience to schemata from the bottom up and linking schemata to experiences from the top down. This bidirectional process is sensitive to context (Kahneman & Miller, 1986). Early versions of the CSM were equally vague, describing matching as a process of finding symmetry between symptoms and labels, that is, as a built-in need to search for and find abstractions to fit concrete experiences and to find concrete experiences to make sense of abstractions (H. Leventhal, Meyer, & Nerenz, 1980), an approach consistent with the English empiricist view espoused by John Locke (Andrews, Vigliocco, & Vinson, 2009).

Data do, however, support the hypothesis that an identifiable set of elements is involved in the linking process. As Bishop (1991) suggested, the elements fall into the five domains of illness representations: identity, timelines, cause, consequences, and control. The linking elements in the identity domain are common sense and based on sensory patterns (e.g., is the sensation sharp, dull, or throbbing?) and location (e.g., chest, leg, or arm)—the real estate of the mind. Linking elements in the timelines domain are equally common sense and complex; they include rates of onset, duration (acute versus chronic), and rates of decline (which overlap with linking elements in the control domain). Control linking elements are highly varied and range from home remedies (e.g., aspirin, chicken soup) and prescribed medications (Horne et al., 2004; Horne & Weinman, 2002) to more complex, threatening, and sometimes noxious interventions (e.g., surgery, chemotherapy). Causal linking elements include triggers (e.g., falls, ingested substances); long-term, slow-acting, potentially changeable lifestyle elements (e.g., smoking, diet, physical activity, stress); and stable features of self (e.g., genes, phenotypic features). Severe pain and physical dysfunction (e.g., the inability to rise from bed or to walk) are examples of immediate consequences with implications for managing activities of daily life.

These elements are used to link experience (i.e., somatic sensations, functional changes, and alterations in experience following the enactment of a procedure for control) to one or more underlying illness prototypes. The result is activation of an illness representation, a concrete and concept-rich hypothesis as to the nature of the condition. The representation creates the framework for further action, that is, "hypothesis testing" in which the passage of time and results of testing confirm and

expand the initial representation or disconfirm it and encourage a search for further information (typically social in nature).

THE INTERACTION OF EXECUTIVE AND AUTOMATIC, IMPLICIT PROCESSES IN CARDIAC DISEASE

Executive functions interact continually with the automatic matching process we have just described. This can be seen in the contrast between patient responses to symptoms of myocardial infarction (MI) and heart failure (HF). The dynamics also provide insights into the executive self's reliance on the abstract features of illness representations when integrating its judgments of illness with procedures and action plans. The data also suggest how different methods for conceptualizing and assessing illness and treatment prototypes will affect the development of interventions for the management of these life-threatening conditions (see [Figure 1.3](#)).

Myocardial Infarction

Bunde and Martin (2006) conducted a detailed analysis of the factors affecting swiftness of care seeking following the onset of an MI. They interviewed 433 patients, on average, 8 days following hospitalization for MI. The interviews consisted of a detailed review of the emotional experience at symptom onset, the perception of factors affecting symptoms, actions taken to interpret and manage symptoms until deciding to call for care, and the time of arrival at the hospital.

The factors associated with swifter care seeking included prior history of MI, location of symptoms (i.e., the chest and arm pain), severity of symptoms, and sweating. Location and the number and severity of symptoms most likely led to care seeking because they are consistent with a prototype of MI. Sweating, which is usually associated with physical effort, was an ambiguous and unsettling cue because the patients were not exerting themselves. The ambiguity added motivation to seek care in order to define what was happening (Cameron et al., 1995). Increased delay in care seeking was associated with gastrointestinal distress, an experience that did not match the MI prototype, and depressive symptoms as measured by the Patient Health Questionnaire depression scale (PHQ-9; Kroenke & Spitzer, 2002). Although total scores on the PHQ-9 were related to a longer delay, a post hoc analysis showed that the effect was attributable to two items: feelings of fatigue and sleep disturbance, suggesting that lack of energy rather than a true depressive symptoms was responsible for the increased delay in care seeking. An interesting feature of the data was the independence of the three prototype checks from reports of depression; location, pattern, and fatigue had separate and independent effects on delay. Thus, the decision to seek care, an executive action, involved a self-made and socially reinforced response to a commonsense representation of a heart attack, and it was slowed by an overall state of fatigue.

Heart Failure

Heart failure, cardiac muscle dysfunction leading to the reduction of the heart's pumping ability, typically follows a history of hypertension and myocardial infarctions. Heart failure, however, does not manifest the same location and temporal features as symptoms of MI; that is, it is not accompanied by the abrupt onset of severe pains in the chest and/or arm or sweating. Rather, the symptoms of heart failure include chronic fatigue, swollen legs, and breathlessness—symptoms that lack an abrupt onset of pain, are chronic, and do not occur in the heart. In addition to failing to match the prototype of a heart attack, the location and temporal features of heart failure match alternative prototypes. For example, chronic fatigue and swollen legs may be interpreted as part of the aging process, and breathlessness may be interpreted as a symptom of a pulmonary problem. Because the symptoms of heart failure do not match the prototype of a heart condition, it should be no surprise that these symptoms do not lead patients to perceive themselves as having a heart disease. Furthermore, because these patients do not recognize the presence of a heart problem, they fail to seek care when experiencing symptoms of heart failure. That is, the lack of a clear representation results in the inaction of the executive system.

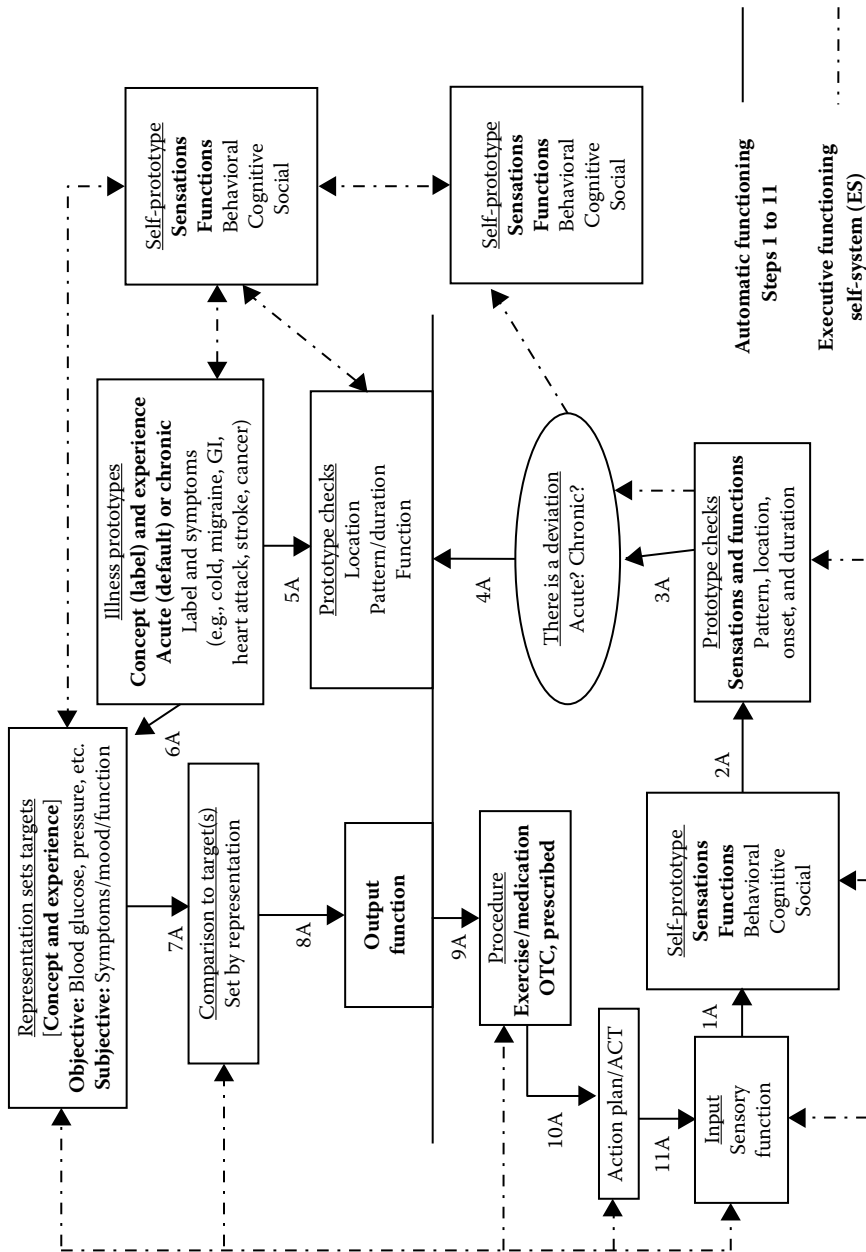


FIGURE 1.3 Numbered arrows (1A to 11A) identify pathways for automatic control: from detection of a deviation through activation of a representation of somatic cues to feedback from action (11A). Dashed arrows represent monitoring and efforts at behavioral control by executive functions of the self-system (ES). The sequence of processing will vary with prior history: automatic preceding EF for familiar illnesses, simultaneously for novel somatic changes that do not immediately match to a prototype. EF is increasingly active in the near term, fading out as self-management is automated. Coherence and long-term maintenance occur when automatic and executive processes have common features.

Qualitative interviews with patients diagnosed with heart failure provide vivid examples of the mismatch between symptoms of heart failure and common-sense models of heart disease (Horowitz, Rein, & Leventhal, 2004). Patients state, for example:

When you hear about having heart problems you're supposed to feel maybe a pain in your left arm, maybe a pain in your chest, or pressure. I couldn't describe what I felt as pressure but I guess it must have been that, uh because I had to struggle in order to talk ... if I had chest pain, and then I would have said, okay, I'll call and say I'm having chest pain but it didn't just seem like anything came together where I could call. (Horowitz et al., 2004, p. 634)

Because heart failure symptoms fail to match a prototype, that is, because the symptoms are not anchored in a conceptual diagnosis, the symptom experience lacks the conceptual component that is critical for connecting different types of symptoms experienced at different time points and integrating these experiences with procedures and action plans for treatment. This is evident in the following exchange:

Interviewer (I): How do you make that decision that it's time to go to the emergency room?

Patient (Pt.): These things seem to happen in the middle of the night so I don't call doctors.

I: You said you weren't feeling that great ...

Pt. I was kind of tired ... didn't seem to be anything out of the ordinary.

I: Were there any warning signs earlier?

Pt.: Not that I could detect.... I didn't feel that great. Oh, I guess that I could have gone to the doctor after I had that collapse on the hallway floor. (Horowitz et al., 2004, p. 635)

The behavioral response, an executive decision, is symptom driven and time specific when symptoms do not match and activate a conceptual category or prototype (Bishop, Briede, Cavazos, Grotzinger, & McMahon, 1987). Thus, patients know they "have" heart failure, but the concept is an empty label because it is not connected to concrete experience. The symptoms associated with heart failure, for example, fatigue and the collapse on the hallway floor, are related respectively to aging and a chance episode that might be age- but not heart-related. [Figure 1.3](#) depicts the ongoing self-monitoring of discrete experiences as the executive system attempts to make sense of somatic cues that do not automatically fit an illness prototype.

CONCEPTUALIZATION AND ASSESSMENT OF PROTOTYPES

Given the critical role played by prototypes in the generation of illness representations, investigators have used a mix of empirical approaches in attempts to "map" the prototype domain. The differences in methods reflect differences in the conceptualization of these memory structures and how they contribute to the activation of illness representations.

Clustering by Judgments of Similarity and Clustering by Elements

D'Andrade and colleagues (1972) used multidimensional scaling to generate a hierarchical model of people's perceptions of diseases. The picture emerged from an analysis of similarity judgments of pairs of disease labels, every disease paired once with every other one. The multilevel tree structure that emerged showed that diseases branched successively on the basis of their causes, control, symptoms, and impact on function rather than factors involved in diagnosis. The maps of illness labels generated by multidimensional scaling overlapped considerably with the experiences defined in the CSM though they differed somewhat across cultures; that is, the maps generated by multidimensional scaling were more easily interpreted for English-speaking Americans than for Mexican participants. Recent data show that Hispanic Americans are more likely than either whites or African Americans to perceive themselves as having asthma only when they have symptoms (Halm et al., 2006).

Bishop (1991) examined how prototypes affect perception and judgments by investigating how participants would respond to and time their responses to sets of symptoms assembled either randomly or to represent specific prototypes. The symptom sets were based on the assumption that everyone has fairly well defined prototypes for many such everyday acute conditions as head colds, stomachaches, or stress headaches and prototypes for a number of serious and potentially life-threatening conditions, among them diabetes, heart attacks, and cancers. Symptom sets that “fit” specific prototypes were more easily and more quickly identified (labeled) than were randomly selected sets, and they elicited more comprehensive and fully elaborated representations (e.g., perceptions of causes and consequences). Bishop (1991) suggested that illnesses are formed into prototype clusters if they are perceived to be similar to each other with respect to cause, consequences, control, timeline, and the like; he suggests that these shared properties need not correspond to the “biological reality” of these illnesses. For example, people are fearful of and avoid being near and having any physical contact with individuals with HIV/AIDS because they group AIDS with other contagious conditions (Bishop, 1991). The suggestion that the representations of a specific illness can affect behavior because its features (e.g., causal beliefs, symptom experiences) place it in clusters with illnesses with quite different biomedical features testifies to the importance of the conceptual level of illness representations for executive functioning. It also makes clear that categorization or clustering can lead to actions that are biologically invalid. We suspect that the common tendency to respond to chronic, life-threatening conditions as though they are acute and self-limited, namely, treating symptoms and ignoring the underlying condition, occurs far more frequently than not and poses more serious consequences than anticipated for individual health and health care costs.

Clusters, Disease-Specific Prototypes, and Episode-Specific Schemata

Clusters of features forming groups of related-disease prototypes and illness-specific prototypes are two of three suggested ways of conceptualizing the memory structures that capture experience and activate illness representations. The third way suggests that the memory structures are episode specific. Croyle and Barger (1993) have pointed to the contrast between Bishop and Converse’s proposal (1986) that the activation of representations involves the matching of symptoms to a generalized prototype and Leventhal and colleagues’ description (H. Leventhal, 1982, 1986; H. Leventhal & Diefenbach, 1991) of the process as an integration of current symptoms with an episode-specific prototype. Bishop and Converse’s model is supported by data showing that symptom sets constructed to match a prototype are more quickly labeled and better recalled than a randomly constructed symptom set. H. Leventhal and colleagues’ initial basis of their formulation, namely, that episode-specific memory schemata underlie the decoding of somatic sensations and the formation of illness representations, was based on clinical reports of phantom pain. Phantom pains are most often reported following limb amputation, and the pain embedded in the phantom limb is typically identical to that experienced in an episode immediately prior to amputation. The somatic sensations of limb and pain appear to be stored in perceptual memory (Melzack, 1992), and the complexity of the memory is highlighted by the manner in which the pain can ebb and flow as the phantom limb changes its apparent position. Croyle and Barger (1993) suggest that “only frequently experienced illness, such as the flu, stimulates the development of prototypes” and that “severe or unusual episodes, however, may serve as a direct basis for comparison” (p. 34). Although Coyle and Barger’s position is likely a valid resolution of H. Leventhal and colleagues’ and Bishop and Converse’s viewpoints, it is basically an issue for future theoretical and empirical analysis. Its significance will become apparent when we discuss the cultural and social contexts of CSM formation in the final section.

SELECTING PROCEDURES AND CONSTRUCTING ACTION PLANS

Early studies on fear communication (summarized in H. Leventhal, 1970), studies on preparing patients for responding to noxious medical examinations and treatments (Johnson, 1975; Johnson &

Leventhal, 1974), and more recent studies of implementation intentions (Gollwitzer, 1999; Orbell & Verplanken, 2010; Sheeran & Orbell, 2000; Sullivan & Rothman, 2008) have all tested the benefits of implementing action plans for behavioral success. Their designs were experimental and involved either providing participants with plans or instructing participants to form intentions to act to specific cues and to reach specific goals. Similarly, H. Leventhal et al. (1965) exposed participants to strong or mild threat messages about the risks of tetanus and randomly assigned some participants to an action plan condition in which they were given a map of their university campus with the health service clearly marked, asked to review their class schedules, and told to find a time when they would pass the health service when changing classes. Action planning involved a review of daily behavior in one's local environment to identify specific cues of place and times that fit ongoing daily behavior patterns and were suitable niches for taking action. The plan was designed to meet an immediate goal (i.e., inoculation) and a longer term goal (i.e., resistance to tetanus). The importance of specifying a goal was clear, for selecting a locus and a cue for action did not lead to inoculation in the absence of a high- or low-fear message that established the goal of avoiding tetanus. The longer term goal justified finding a locus and setting a cue to act on the proximal goal of inoculation. Studies of implementation intentions replicate these conditions by asking subjects to select a cue for action or by specifying a cue for action, specifying the selection of a goal for action, and asking participants to choose the context for cueing action (Orbell & Verplanken, 2010; study 3). Sampling studies in this burgeoning literature reveal, however, that relatively little is known about how people generate action plans in their community and home environments.

Although the CSM has not yet generated studies examining how individuals generate action plans in their local environments, it does point to a number of issues and suggest hypotheses respecting the process of planning. Planning to adopt a new behavior, to stop or reshape an ongoing behavior, requires monitoring the context for action and the action itself, which are executive functions. It also requires selecting and testing cues for initiating and evaluating action, that is, determining whether the cues are available, reliable, and valid indicators for evaluating outcomes. Tools used for focusing attention, monitoring and reviewing the environment, and monitoring and shaping behavior are available and are part of everyday parlance. For example, such comments as "look closely" (focus attention), "stop a minute," "slow down," "take a second look," and "step back" (Hardy, 2006; Landin, 1994; Salomon & Globerson, 1987) identify specific tools that are used for improving performance in sports, playing musical instruments, controlling impulses, and avoiding persuasive scams. They are tools to locate specific places for modifying performance and improving self-regulation in a specific environment.

TRANSLATING THE CSM INTO CLINICAL INTERVENTIONS

Although our understanding of the processes involved in self-management has deepened over the past three decades, few efforts have been made to translate these insights into interventions to improve communication about and management of chronic conditions in clinical settings (see McAndrew et al., 2008, for notable exceptions). The failure to do so is surprising given that five chronic conditions consume approximately 70% of all health care spending (Halverson, 2007) and low-cost treatments are available for effective control of at least four of the five (asthma, two cardiovascular diseases [MI and HF], diabetes, and depression). Furthermore, evidence from randomized trials indicates that some behavioral interventions can control and perhaps prevent disease onset. For example, four randomized trials have shown that behavioral interventions can control, if not stop, the progression from a prediabetic state to diagnosed diabetes, and they do so for a period of 2 to 4 years (Diabetes Prevention Program Research Group, 2002). Behavior change is also more effective than medication in controlling the progression of diabetes (Diabetes Prevention Program Research Group, 2002; Tuomilehto et al., 2001). This evidence is especially important because diabetes is reaching epidemic proportions worldwide. Also, because diabetes is a systemic disorder, it creates the conditions for such comorbidities as cardiovascular disease,

kidney failure, and blindness; thus, controlling diabetes can affect multiple conditions (Fleming et al., 2001). Adherence is still a major problem, however; as former U.S. Surgeon General C. Everett Koop stated, “Drugs don’t work in patients who don’t take them” (quoted in Osterberg & Blaschke, 2005, p. 487).

WHERE DO WE START?

The diabetes prevention trials provide proof of a concept: behavior can be changed, and change can slow or stop disease progression. However, the methods used are unlikely to be translated to practice. Patients in the behavioral arm of the Diabetes Prevention Program trial had face-to-face sessions with a behavior-change therapist, received numerous phone contacts, and were included because they were highly motivated (Diabetes Prevention Program Research Group, 2002). Can we do better given what we know about how patients manage health and illness? Experts in health policy start from the top down, addressing such issues as affordability and access, the integration of care, and what practitioners are paid to do. Psychologists begin at the ground level, moving from how patients understand illness and treatment, through relationships with providers, to barriers to effective self-care in home environments. The diabetes trials support our view that interventions need to start with both top-down and bottom-up approaches. An effective behavioral intervention will be completely useless if it cannot be implemented in real-world settings.

The CSM and Changing the Microsystem

We believe the CSM is particularly well suited as a framework for generating interventions in clinical settings and doing so within the constraints of many health care systems. Although illness representations form an excellent starting point for intervention, it is critical to recognize that illness representations will change with changes in the progression of the underlying disease and in response to treatment and lifestyle behaviors. Because the CSM is based on a control systems approach, it is inherently dynamic. Thus, illness representations create a set of changing goals or targets for behavioral management, some of which are proximal and others of which are remote. In addition, the CSM assumes these targets are both concrete (i.e., experience-based features of representations) and abstract (e.g., such concepts as good health). It is also presumed that concepts differ in connectedness to experience: concrete concepts are more tightly linked to experience, and remote goals are more likely to be abstract. It is also clear that abstract concepts play a critical role in linking temporally separated experiences and targets; for example, patients see some symptoms (e.g., a fall on the floor; breathlessness; swelling feet) as separate events unless they are linked by the data-rich concept of heart failure (Horowitz et al., 2004). Finally, the CSM has generated evidence indicating that one can identify the elements critical for both intrapsychic and interpersonal discourse—the prototype checks that connect ongoing experience with illness prototypes and communicate the details of experience to others. The prototypes underlying the system, that is, the perceptual and procedural content and concepts that define the self and specific diseases, are more stable than representations. The self-system is the most stable and difficult to change.

Representations of procedures for prevention and control and the action plans in which procedures are embedded form the second set of processes involved in the CSM’s conceptualization of self-management. These representations are also central in the discourse among patients, practitioners, family, and friends. Behaviors that produce substantial changes in salient, concrete targets of illness representations, and do so more quickly, establishing identity and timeline, will form coherent bonds with the illness model. If these behaviors are not connected to the abstract features of the illness representation, however, the behaviors are very likely to be episodic or present only when symptoms are present; and so they will be stopped when symptoms clear. To initiate and sustain a health-promoting or illness-controlling

behavior, the intervention needs to create a plausible link to targets defined by the illness model, specify timelines for effects, and ensure that both the actions and their effects are perceived as action progresses and are anchored in a conceptual framework that links current moments with future goals. These intervention characteristics are complex criteria, and few studies meet these requirements.

Successful Interventions

The studies that preceded the development of the CSM—for example, the examination of the effects of fear communications on attitudes and behavior and the effects of preparation for difficult medical treatments—were intervention based. A main contribution of the fear studies was the validation that action plans played a critical role in translating attitudes (representations of health threats) into active behavior (H. Leventhal, 1970). The fear studies anticipated two important issues validated in later studies: the importance of establishing a cue to elicit behavior and the need to specify a goal or rationale for performing the behavior. Action plans had no effect on performance if not associated with a message that defined the possibility and widespread presence of threat (H. Leventhal, 1970). The fear component of the messages used concrete images to depict the cause and consequences of the disease and embedded the imagery in a conceptual framework that defined the causal agent as universal in the environment; concrete targets were everywhere and unavoidable. Action planning was assisted pictorially with a map of the campus and verbally by instructing participants to locate the recommended action at an optimal point in their daily schedules, thereby defining the cues for action. Timelines were not specified, nor were concrete consequences; participants could think they were safe following inoculation but had no concrete evidence of safety. The college students' prototypes of preventive treatments were sufficient to generate meaningful frameworks for action.

Many of these features have been replicated in studies of implementation intentions that examine how the specification of cues for action bridges the gap between intention and action and how the specification of goals (i.e., making behavioral goals more specific) helps to bridge this gap (Bodenhimer & Handley, 2009; Orbell & Verplanken, 2010). Planning, that is, reviewing ongoing behavioral patterns to locate interstices for performing recommended actions, is ignored or attended to implicitly. By contrast, planning is the most important feature of action plans in the CSM, and it is a key factor in cognitive behavioral therapies (e.g., Wilson & Vitousek, 1999). In addition, studies of implementation intentions tend to ignore the conceptual distinction between the nonverbal (perceptual and procedural processes) and abstract features of plans and goals. We believe that attending to both aspects of plans and targets or goals for action is a necessary component for any successful intervention. The limited attention to perceptual and procedural processes is apparent in an otherwise interesting study contrasting the goals associated with an implementation intention to do something (e.g., exercise), in comparison to the goals associated with a plan to *not* do something (Richetin, Conner, & Perugini, 2010). For example, goals for eating and not eating meat were assessed using attitude questions that measured general feelings about meat eating ("What is your overall attitude toward eating / avoiding eating plenty of meat?") and general beliefs about exercise (e.g., staying fit versus having more time to do other things). The data provide convincing evidence for the hypothesis that the goals for action and for nonaction are different. The attitudes and goals are, however, described in a relatively abstract fashion. For example, it is unclear whether meat avoiders avoid the idea of meat or are repelled by the sight and odor of blood and cooked flesh. Likewise, are meat eaters attracted by the sight and odor of gravy or by the chewing of a tasty piece of beef washed down with a glass of red wine? The CSM would argue that changing these preferences and behaviors requires addressing the concrete experience that will be linked to a new abstract goal structure (e.g., meat eating is conceptualized as providing a source of proteins to build muscle mass). Modifying specific behaviors that create the cognitive and emotional reactions involved in taste preferences would be the likely approach for a cognitive behavioral treatment and the CSM.

The CSM in Clinical Practice

Developing and testing hypotheses in the clinical setting is the major challenge facing the CSM and all situated models. Two different approaches have been taken to implement the CSM in clinical settings. The first and earliest used a structured approach for all patients, whereas recent examples have been more flexible and have incorporated features common to cognitive behavioral therapies. The second approach aims to improve the biomedical validity of patient representations and the efficacy of their action plans by modifying the behavior of the clinician, influencing how the clinician explores information and presents it to the patient.

Using a Structured Approach

Earlier versions of the CSM used the same intervention for all patients to facilitate acceptance of and effective responding to noxious medical interventions. There is also a second, larger set of studies supporting the value of focusing attention on sensory features and providing simple procedures for responding during medical procedures. In the first of these studies, patients scheduled for a morning endoscopy were contacted by a nurse the evening before the examination (Johnson & Leventhal, 1974). Half of the patients were randomly assigned to view photographs and listen to texts that described the basic features of the examination room and its equipment; the other half saw photographs and listened to text that described what someone would feel when undergoing each of the steps depicted (e.g., throat swabbing) and the specific actions to take at each point (e.g., mouth breathing). Focusing attention on somatic sensations normalized patients' interpretations; the sensations were no longer cues of impending threat, and heart rates decelerated during the examination for the patients prepared to respond to the sensory experiences. Numerous studies have replicated these findings (e.g., Johnson, 1996).

Two other sets of investigators have focused on identifying and correcting features of illness representations to affect behavioral responses and outcomes following life-threatening myocardial infarctions. The CSM has been used in a recent approach to the reconceptualizing experience in highly stressful situations (Donovan et al., 2007; Ward et al., 2009). This five-step program is designed to develop shared treatment preferences among patients and proxies (typically a family member) prior to complex cardiac surgery. It begins with a formal assessment of pain representations (the experiences captured by concepts of the five illness domains), followed by the exploration (step 2) of misconceptions uncovered in step 1. Step 3 is a discussion of the deficits created by these misconceptions and is followed by step 4, the provision of information to reshape and replace these misconceptions. The final step involves clarification and a summary discussion. The intervention led to impressive gains in shared treatment preferences in comparison to patients and proxies in the standard care control group (81% versus 19% complete congruence). It also reduced barriers to analgesic use and lowered ratings of usual pain severity; it did not, however, improve coping and well-being. The program focused more on creating valid integrations of experience and concepts than teaching specific responses. This promising approach could be strengthened by constructing action plans with attention to the timing and quantity of changes in pain and the social and psychological context for action.

The second study focuses on the difficult task of reducing the time from first notice of symptoms of myocardial infarction to arrival at hospital emergency rooms for treatment (Dracup et al., 2009). Although promising on several counts, including success in altering an array of such cognitive factors as beliefs respecting heart attacks and need for immediate treatment, the intervention did not reduce total time to care seeking. The failure to achieve this important goal may have been a consequence of insufficient attention to addressing features of illness representations of patients who had prior episodes of MI. Many of these patients may have been told, "You're okay, you can go home now," comments that patients may interpret as meaning they are pain free and cured, an inference that does not distinguish the underlying systemic disease from the manifest episode. Patients also may not realize that future symptoms may differ from past symptoms. A second problem may have been insufficient attention to the formation of action plans, which could have been improved

by encouraging patients to call emergency medical services (EMS) when symptomatic and making clear that EMS staff members expect and want patients to call.

Using Cognitive Behavioral Techniques

A second approach involves training clinicians to use psychological models. Many investigators have focused on training to enhance the use of psychological principles and models by medical practitioners. Because this literature is vast, we comment only on selected examples of studies that have examined the use of cognitive behavioral techniques similar to those addressed by the CSM.

A systematic series of studies by Ley (1977, 1982) examined how the organization and sequencing of presentation of information affected patient understanding and adherence. Multiple studies indicated that patients better understood, remembered, and adhered to treatment protocols when information was organized, for example, by presenting all treatment advice and action plans separately from threatening diagnostic information to ensure that patients were not focused on threat when listening to treatment options. Recent efforts demonstrate that physicians and pharmacists can be trained to address illness representations, action plans, and goal setting (De-Ridder, Theunissen, & van Dulmen, 2007; Horne & Weinman, 1998). Both studies highlight the specificity of effects: in the first study, training enhanced communication only in the training's focus area; and in the second, the specification of goals relevant to the biomedical demands of treatment led to better outcomes.

An early study by Inui, Yourtee, and Williamson (1976) trained physicians to use the health belief model when educating patients with hypertension. By focusing on various aspects of management, including the asymptomatic nature of hypertension, patients were found to be more adherent and, most important, their blood pressure control improved over the following months. Although we do not know precisely which components of training affected communication and which aspects of communication affected patient behavior and health outcomes, the description suggests that training focused on both the representation of illness (the asymptomatic nature of hypertension) and plans for implementing treatment. Examination of these studies points to the difficulty in discerning which elements of theory-based interventions are actually used and which of those used are responsible for the intervention's effects.

Using Clinicians as Educators

A third approach conceptualizes the clinician as educator. A central issue raised during our discussion of sharing illness representations is whether a practitioner can infer a patient's illness and treatment representations and action plans during the typical clinical encounter. Given the time constraints and biomedical issues facing practitioners, is it realistic or necessary to take on this burden? A recent study by Phillips, Leventhal, and Leventhal (2011) suggests that it is. They found that patients were more likely to report higher levels of adherence and resolution of their problem at the one-month follow-up interview if they reported during the baseline interview that during the medical visit their physicians (a) discussed the meaning of symptoms, (b) provided a specific response for management, (c) stated treatment outcomes, and (d) discussed possible actions if outcomes were not as expected. In addition, none of the patients who reported that their physicians did all these things had to return for care because their problems had not resolved, whereas the patients who did return for care had not reported these physician behaviors. We do not know why the clinicians informed some patients and not others with these details. It appears, however, that their comments worked and reflected the CSM.

The findings of Phillips, Leventhal, and Leventhal (2011) question the widely held opinion that improving adherence requires improvements in the clinician's psychosocial sensitivity (i.e., the clinician's ability to recognize and accept the patient's cultural background, to display empathy, and, of course, to listen) regardless of how the medically relevant information is integrated with the patient's prior beliefs and experiences. The data from their preliminary study suggest that empathy and liking may be essential contexts for communication, but they are insufficient for adherence and

positive health outcomes. Their data found no link between physician psychosocial skills (i.e., bedside manner) and reported adherence. In fact, satisfaction was negatively related to reported adherence and improvement of the condition at 1-month follow-up. In addition, the patients requiring follow-up treatment were as likely as not to report high levels of practitioner psychosocial skills and satisfaction with the visit. Therefore, addressing illness and treatment representations and action plans appears to be an additional and necessary ingredient for adherence and treatment outcomes.

The results of the Phillips et al. (2011) study, as well as our recordings and observations in clinical practice, suggest the need to specify how to use the CSM to personalize clinical practice at the behavioral and biomedical levels. Specific ingredients of the CSM address personalization, though few have been clearly spelled out. First, it is essential for the clinician to grasp the patient's perspective; even a superficial recognition of the patient's representation can be an effective starting point for communication. Second, the CSM suggests that the patient's experience, symptoms, and function provide tools for communication. A patient's prototype checks link experiences to illness prototypes. Some links, such as recognizing a heart attack, are automatic; others emerge from conscious queries by the executive system. The CSM suggests that effective communication requires that these experiences be made public (i.e., shared with the clinician) and framed appropriately (i.e., attributed to a valid source). The experiences should also be related to management; that is, clinicians should explain how the symptoms should change, identify the time frame for change, discuss the meaning of change, and propose the procedures and plans needed once the cues are gone.

These points are illustrated by an encounter between a patient and his internist after the patient was discharged from the emergency department with negative findings for a heart attack. Prior to discharge, the patient was told that he needed to be checked by his internist in case something had not shown up on his tests. His internist read the history and saw the patient seated with his head down, his hand on his chest, and a worried look on his face. The internist proceeded to address four issues by: (1) acknowledging public recognition of the symptoms suggesting heart attack; (2) discussing the patient's interpretation of his symptoms; (3) locating the actual source of his somatic complaints and reframing their meaning if possible; and (4) suggesting treatments for the current episode as well as long-term treatments for underlying risks. Although the less experienced practitioner might attempt to address these issues with words and test results, the expert clinician attempted to detect the source of the symptoms and by doing so reframed their meaning.

The physical examination provided the tool to explore the chest and was an opportunity to enrich words with experience. Exploring and applying pressure to the patient's chest elicited a complaint from the patient: "That's the pain." A repeat of the pressure reproduced the symptoms again. The symptoms were now public, that is, shared with the physician. By eliciting the symptoms at will, the internist proved that the symptoms were "real." She was now able to understand their causes. She stated, "I can't push your heart, but I can push your sternum, and I suspect that you have an inflammation of the joints between the ribs and sternum, called costochondritis. We can treat it with an over-the-counter anti-inflammatory drug for a short time, three to five days." It is not surprising that the patient no longer appeared terrified; the clinician and his body had provided a persuasive explanation for his symptoms, and the internist had provided a simple treatment.

This encounter meets the conditions for adherence reported by Phillips et al. (2011); the internist prescribed a treatment and discussed the time frame and expectations for outcomes. The clinician did not stop, however. Instead, she used the experience as an opportunity to address the patient's risk factors, for example, his family history of heart attack that led him to suspect he was having a heart attack. This was now the focus of discussion, and the internist provided a set of recommendations to address underlying systemic sources of risk. Clearly, not all presenting complaints permit such a comprehensive approach, but many can be addressed with some of the features of the preceding example. The clinical examples raised at least three interesting issues. The first concerns the similarity between the skilled use of the CSM and the cognitive behavioral approach to treating panic disorder (e.g., Clark, 2004). The second is the problem that arises in creating interventions

that address the gaps and misunderstandings in each patient's self-management process. Addressing representations and action plans that are person specific may violate the rules for maintaining the fidelity demanded in the typical behavioral clinical trial. Third, as the complexity of the prescribed behavioral changes increases, there is a need for integrated team care, where the skills of participating specialists address those aspects of treatment relevant to their specialty with knowledge of its fit to other components.

CONCLUSION

PREMISES UNDERLYING THE CSM

It is worth emphasizing the basic premises underlying the overall approach and details elaborated on in this chapter. First, we view the common-sense model as an effort to develop a systems approach to the cognitive and affective processes underlying preferences, decisions, and behaviors for managing illness and improving health. We do not view the CSM as a proprietary framework; it is an approach to analysis from which investigators are encouraged to borrow. Second, the sequence of studies that led to the models that preceded the CSM and the CSM itself parallel findings in the cognitive and biological sciences; investigators should continue to borrow freely from these sources (with attribution, of course, when the borrowing is concept or data specific). The most recent, startling, and amusing parallel is research suggesting that laboratory rats represent objects (e.g., a nest) using features that resemble the domains of underlying illness prototypes (e.g., location; pattern; implied function, cause and consequences; Lin, Chen, Kuang, Wang, & Tsien, 2007).

Our third premise is that CSM differs from other theories of health and illness behavior because its properties parallel those of cognitive and biomedical models. The most fundamental of these properties is the focus on problem-solving processes, that is, how the interaction between information and underlying prototypes activates the representations of specific illnesses, procedures for treatment, and action plans for implementing procedures. The composition of representations (i.e., the variables in the five domains) and their changeability in response to behavioral feedback and social communication is shared with some models of cognitive behavioral therapy. Three key differences in identification of the details involved in information processing illustrate the differences between other models and the CSM model: (1) the specification of prototype checks for the recognition and activation of illness representations and their role in the appraisal of treatment procedures (both intra- and interpersonally); (2) the specification of the cognitive heuristics and behavioral tools available to executive functions; and (3) the search for pathways linking illnesses and treatment representations to psychological distress (anxiety and depression). The CSM also identifies important features of experience and concepts involved in creating action plans to guide behavior. Among the most important of these is the identification of critical treatment time frames (i.e., rate of change and time for benefit) and their relationship to perceived illness-related time frames. From our perspective, if the CSM did not strive for specificity in concepts, it would not merit being called a theory.

IMPLICATIONS OF THE CSM FOR RELIABILITY OF INSTRUMENTS AND CLINICAL TRIALS

This chapter has raised a number of questions respecting hypothesis testing and the development of evidence-based practices; these questions relate to the systems-based framework of the CSM. Both hypothesis testing and clinical application from the CSM framework are centered on the individual. Individuals can be grouped by disease and other broadly defined demographic factors, and these groupings can be used as moderator variables. Individuals differ, however, on the specific properties of their disease (e.g., the genes expressed), their illness and treatment representations, and their action plans. If these individual differences are common among large numbers of individuals, these

groups can be identified as moderators in treatment studies. However, the CSM is primarily focused on the dynamic among the processes specific to an individual, his or her specific qualities, life experiences, and illness and treatment.

The dynamic nature of representations and action plans compromises traditional procedures for assessing the reliability of assessment instruments because adequate test-retest reliability assumes the stability of individual differences. Assessments of validity are further complicated because the predictive and discriminant validity of a measure in the commonsense framework depends on context; that is, validity is a function of the values of other factors in the CSM system. What is needed and generally lacking is calibration, or the ability of an instrument to replicate a reading in a context specified by theory. For example, a thermometer would be useless if it consistently gave the same temperature reading; rather, its utility stems from its ability to give the proper reading in the proper situation (e.g., a reading of 0 degrees Celsius in ice water and a reading of 100 degrees Celsius in boiling water). Similarly, any CSM-based assessment must account for the dynamic nature of illness and treatment beliefs.

The CSM also suggests that problems exist in current approaches to intervention trials. Trials are inherently more complex if a theory suggests pretreatment individualization, that is, if the intervention plans to address gaps in individual participants' illness and treatment representations and action plans. A key question is whether the randomized trial—where the same treatment is applied to all persons, with attention to such moderators as age, education, and treatment representations—is the appropriate mechanism for creating and testing clinical interventions. We suspect these traditional designs and their reliance on significance testing is neither the best conceptually nor the most efficient. Indeed, we suspect it is far less efficient and valuable than a combination of time series designs with a more Bayesian flavor (Gallistel, 2009).

Finally, if the reader is entertaining our beliefs about the essential properties of a theory of health and illness behavior and shares some of our concerns about the methods now adhered to in the development and testing of hypotheses and clinical interventions, we can regard our chapter as modestly successful. These issues have motivated the two senior members of our team for many decades, are now embedded in the thinking of our younger members, and we believe they were forces that motivated Dr. Andrew Baum, to whom we dedicate this and our future efforts.

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8 What Are the Health Effects of Disclosure?

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9 Coping in Social Context

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